Title Purchasing, Providing and Participating in Mental Health Services

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PURCHASING, PROVIDING AND PARTICIPATING IN MENTAL HEALTH SERVICES

by

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ABSTRACT

This thesis examines the implications of the changes introduced by the NHS and Community Care Act 1990 for mental health services. It focuses on two main issues. Firstly, the impact on mental health services of the 'market' system of purchasers and providers introduced by the 1990 Act. Secondly, the extent to which the 1990 changes had led to any increase in user participation and involvement in the planning and delivery of psychiatric services.

Analysis of the existing theoretical literature found that there had been little research which focused on the specific implications of health care 'markets' for mental health services. In addition, much of the work on the development of psychiatry had not focused on the role of the local context in influencing the nature of mental health service provision. In this thesis these issues are explored through a case study of the mental health services of one English county. Semi-structured, qualitative interviews were undertaken with managers, professionals and individuals in purchaser, provider and voluntary sector organisations. People using community mental health services in the county were also interviewed. This contrasts with many previous studies which have tended to concentrate exclusively on users of in-patient services.

The study found that local circumstances played a significant role in the relationships between those purchasing, providing and participating in mental health services. The imminent closure of a large Victorian psychiatric hospital and the uncertainty about which services would replace it had been a source of tension between the newly formed purchaser and provider organisations in the county under study. The lack of any strong existing groups in the local area representing users of mental health services was also significant. It meant that increased user participation in the county after the 1990 Act was reliant on initiatives by managers and professionals rather than organised pressure from user groups and

users themselves. The variety of different local mental health agencies purchasing and providing mental health services in the county called for a degree of co-operation between organisations which conflicted with the competition encouraged by the 'market' system introduced by the 1990 Act.

The focus, first, on psychiatric services in the examination of 'markets' and, second, the importance of the local context in mental health service development provides the basis for the study's contribution to theoretical and policy debates both about the 1990 Act and psychiatric services in general.

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CHAPTER ONE - INTRODUCTION

Introduction

In both human and economic terms, mental health problems and the services that seek to address them, are of great significance in Britain today. Each year around six million people suffer from a 'mental illness' meaning that it is as common as heart disease and three times as common as cancer. Eighty million working days per year are also lost through mental health problems, compared to eight million through alcohol and drink related disease, or 35 million due to coronary heart disease and stroke (Department of Health, 1993). According to calculations made on behalf of the Health Education Authority, mental health costs Britain £32 billion a year, which is half as much again as the defence budget (Brindle, 1997). £4.2 billion of this figure is spent on treatment within the health service, representing ten percent of overall NHS spending. Although there is a high prevalence of mental health problems, there remains a deep rooted stigma attached to both psychiatric problems and the services that seek to address them. And despite the apparent high level of spending on mental health, it has been argued that psychiatric services are under-resourced (Blom-Cooper and Murphy, 1991) and they are often characterised as 'cinderella' services which are neglected and disadvantaged within the planning and operation of the NHS (Read and Wallcraft, 1992). Mental health is also an area where there exists a number of powerful and competing voluntary, user and professional mental health organisations and groups. At both a local and national level these groups often have conflicting interpretations about the most appropriate use of mental health resources and how those with mental health problems should be treated.

It is against this background of a complex and contested area, that this thesis seeks to examine recent policy changes and their effects on mental health services. In this introductory section of the thesis the conceptualisation of social policy which

underpins the study will be discussed. It will be established that the general approach to social policy analysis adopted here is, firstly, to examine the statements of intent contained within government policy and then, secondly, to explore the implications and implementation of these policy statements at the local level amongst those planning, providing and using mental health services. In the light of this conceptualisation of social policy, the final part of this chapter will present three main research questions to be addressed in this study.

To provide some context for the discussion outlined above, however, the broad focus of the study will be outlined first.

Broad focus of the study

The initial broad focus of the study was the implications of a more 'market' orientated approach to the organisation of mental health services. The researcher also had a particular interest in the perspective of users of mental health services and their involvement within service planning and delivery. This had begun during previous work for a voluntary organisation which had a strong emphasis on user involvement and empowerment. These issues were explored through a case study of the psychiatric services of one English county. Using a qualitative approach to data collection and analysis, primarily through semi-structured interviews with individuals planning, providing and using mental health services in the county, the research sought to examine the perceived effect of changes introduced by the NHS and Community Care Act 1990. The merits and problems involved with the case study of only one county and the use of qualitative research methods are discussed in detail later in the thesis, in Chapter Five: Methodological Issues.

The 1990 Act was introduced by the last Conservative government and sought to introduce 'market' structures into the health service with the separation of

purchasing and providing functions. Health authorities became responsible for assessing the needs of their population and purchasing services to meet those needs. The operation or provision of services in the NHS became the responsibility of trusts. The interaction between purchasers and providers would be in the form of 'contracts'.

These changes were promoted as a means of improving efficiency in the NHS. Competition between trusts in the 'market' would force them to offer the best quality services at the cheapest price in order to win or keep contracts with health authorities. Effectiveness would also be increased within the health service by allowing organisations and individuals to have control and take decisions at the appropriate levels. Health authorities would be able to concentrate on meeting the health needs of their populations and trusts would have the power to manage the direct provision of services without unnecessary interference from bureaucracy within health authorities. The Act also stressed that patients or users would be given more say as health authorities were encouraged to consult and involve them in decision making within the health service.

To establish the main research questions that this study would seek to examine in relation to the changes introduced by the 1990 Act and mental health services, preliminary work was carried out involving the examination of official government documents, relevant social policy and professional literature, as well as informal interviews with key personnel in the county under study. Local documentation was also examined, such as Purchasing and Community Care Plans and a Strategic Direction Statement for Mental Health Services produced jointly by the county's District Health Authority (DHA) and Social Services Department (SSD)[1].

[1] Whilst obtaining permission to carry out the research, it was agreed with managers within the county that its location would remain anonymous and therefore to retain this anonymity these documents are not referenced.

Before the specific research questions are discussed, the implicit conceptualisation of social policy underpinning the research will be examined. The next section of this introductory chapter, then, sets out the kind of assumptions about social policy and its analysis which are inherent in this study.

Conceptualisation of social policy underpinning the research

The overall conception of social policy and its analysis underpinning this research is broadly that outlined by Allsop (1995). In setting out her own approach she argues that:

> '. . . the policy process is cyclical. Government statements of intent have been taken as the main starting point. In being implemented, policies may be, and indeed often are, distorted by the interpretations, actions or inertia of lower level actors. Such distortions reflect the relative power of individuals or groups . . . It is therefore particularly difficult to determine policy outcomes; research or evaluation is often required of government policies boldly stated in official documents.'(Allsop, 1995, p. 4)

Central government policy statements, then, are important in defining issues of concern and setting out frameworks, boundaries and constraints within which those planning and providing health and social services at the local level act. These same actors, however, have a role in determining the specifics of how policies may or may not operate within these frameworks, boundaries and constraints. In addition, they may have their own set of concerns and priorities which are different from those prescribed by central government policy.

This kind of characterisation of the policy process advocated by Allsop (1995) is influenced by the work of Barrett and Fudge (1981). In tracing the development of policy analysis, Hill (1993) identifies Barrett and Fudge's work as a challenge to writers of the early 1970s such as Pressman and Wildavsky (1973). Pressman

and Wildavsky themselves had sought to challenge the traditional Weberian model of policy analysis which sees bureaucracy in terms of the separation of politics and administration. Politics is seen as a goal-setting process with administration as the, usually, unproblematic translation of these goals into action. Pressman and Wildavsky argued that the implementation process could transform policy, with organisational and inter-organisational phenomena often subverting the original goals of policy makers.

Barrett and Fudge (1981) criticised this as a rather narrow top-down approach for two main reasons. Firstly they argued that the top-down approach essentially still sees central policy makers as the most important actors and others merely as impediments to the policies and decisions of these key actors. Secondly, they also criticise the top-down approach as being limited to situations where there is a clear policy or statute. Where there is a multitude of directives which have accumulated over time, the notion of a clear policy being passed down is challenged. These two points will be now be examined briefly, focusing on their relevance and application to this research study.

Central and local spheres of social policy

Overall Barrett and Fudge (1981) argued that the strict distinction between policy formulation at the centre and local implementation is a false one as it is often difficult to discern where one finishes and the other begins. They argued that it was more advisable to talk in terms of a policy/action continuum with policy-making and formulation continuing into the so-called implementation phase. In contrast to the top-down approach to studying implementation, a bottom-up approach is suggested involving 'backward mapping'. This involves a focus on local-level decisions and networks, looking at responses to problems or issues without predetermining which forces or relationships affect these responses.

In relation to this research study, while the structure of the thesis itself may suggest a top-down approach it should be stressed that this is not the case.

Although the next three chapters concentrate on the origins and nature of central policy, it is not assumed that the aims, objectives and structures that governments have sought to introduce with these policies have necessarily operated in practice as predicted. Organisations or actors at the local level may bring their own interpretations to bear on these policies and not behave as intended. So, although central government policies are taken as the starting point, it is not assumed that they are dominant or determine outcomes and actions at a local level. The approach taken whilst interviewing key individuals involved with mental health services, was to attempt to explore their perceptions of central policy changes and also find out what they saw as the main issues and priorities for services. Ultimately, using the example of mental health services, this will allow the thesis to explore the relationship between central and local spheres and contribute to the academic debate surrounding it.

The accumulation of social policy

Barrett and Fudge (1981) also highlighted the problems associated with looking at policies in isolation. Directives within a policy area accumulate over time and individuals policies must be seen within the context of other initiatives that have been previously introduced. The consequences of such an argument for this study are that the changes that the 1990 Act sought to introduce must be seen as being introduced into a context of accumulative[2] mental health policy. For this reason, long term historical themes and developments in mental health policy, and the theoretical debates surrounding them, are reviewed in detail in the later sections of the thesis. These include trends such as the move from institutional to community care, examined in Chapter Two, or the challenges to professional dominance of the user movement which are partly responsible for the current emphasis within

[2] The term 'accumulative' refers only to the build up of government prescriptions and is not used to suggest an incrementalist conception of social policy where successive policy initiatives are seen as contributing to an overall gradual improvement in services and conditions. Indeed with regards to mental health policy it has been argued forcibly by Chapman *et al.* (1991) that government assertions of improvements and successes should be viewed critically.

mental health services on the importance of user views, which is explored in Chapter Four.

Barrett and Fudge (1981) advance valid criticisms of the 'top-down' approach in terms of its neglect of the importance of the 'periphery' over the 'centre' and their emphasis on the accumulation of policies rather than the focus on individual initiatives in isolation.

Acknowledging these criticisms, however, the changes introduced by the 1990 Act appear to be a prime example of a top-down intervention. As we shall see in Chapter 3 the changes introduced by the Act were formulated at the centre of government (largely within the Conservative cabinet of the time) and then given over to local health service managers to implement. More precisely the changes can be seen as what Ham and Hill (1993) identified as a 'meta-policy' adjustment. They define such developments as changes to the 'programme shell' which are:

> 'common top-down interventions in public policy, but the analysis of their affects must rest upon an elaborate study of the way in which the balance of power is changed within the implementation system. In purposive language they are concerned with *means* not *ends* and therefore explicit goals cannot be identified, yet they may be of fundamental importance for outcomes and may embody implicit goals.' (Ham and Hill, 1993, p.106)

Such policies, then, primarily affect structures and relationships between actors and agencies at the local level and, as such, this would suggest that their assessment requires an approach which attempts to map out the nature of the change in these structures and relationships.

As discussed by Sabatier (1993), the nature of the 1990 Act would suggest a need for analysis which incorporates elements of both top-down and bottom-up approaches. Whilst the 1990 Act is a top-down intervention, its status as 'meta-policy' adjustment without explicit goals suggests the adoption of the 'bottom uppers'' (sic) unit of analysis (Sabatier, 1993). In attempting to synthesise the best features of the top-down and bottom-up approaches to policy analysis,

Sabatier (1993) argued for an 'advocacy coalition framework of change' in which the most useful unit of analysis was taken as the policy subsystem or network. Within purely bottom-up approaches this unit of analysis was called the 'implementation structure'. In this research, the policy network or 'implementation structure' consists of the main actors within the mental health services of the case study county. In examining this unit of analysis, as mentioned previously, the task for the researcher becomes the 'backward mapping' of this 'implementation structure' to establish the motivations, concerns and relative power of the actors within the policy network. Unlike the pure bottom-up perspectives, however, Sabatier does not completely ignore top-down policy interventions but accepts that their impact must be studied in the context of existing policy subsystems or networks rather than as isolated initiatives from the centre to be aided or hindered by implementation by actors at the periphery.

The next section of this chapter will set out the main research questions to be addressed in this study in analysing the 'implementation structure' of the main mental health actors within study county.

Main research questions

As mentioned earlier in this chapter, the broad focus of this study from the outset was the particular implications of the changes introduced by the 1990 Act for mental health services. This focus was established, as is discussed in more detail in Chapter Three, after examination of the literature on the 1990 Act revealed very little work on their consequences for specific areas of provision such as mental health services.

Within this broad focus, however, three main research questions were established for the study. These will now be discussed in the context of the conceptualisation of social policy underpinning the research, which was outlined above.

The first research question was: What has been the impact on local level mental health actors of the 'market' orientated approach of purchasers and providers introduced by the 1990 Act? In attempting to answer this question, the study would aim to explore the effect of the 1990 changes on the various local actors concerned with mental health in the case study county and the relationships between them. In later sections of the thesis this analysis will be related to the existing research literature which deals with the introduction of 'market' mechanisms into the health and social care sectors in general. In the light of the fact that few studies had sought to investigate the particular effects of the 1990 changes on specific areas of provision such as mental health, this study would aim to examine the specific implications of the 1990 Act for a local mental health service. As outlined above, as a 'meta-policy' adjustment to the 'programme shell' (Ham and Hill, 1993) the 1990 Act had the potential to change the power relations between local level actors. Health authorities in their new role as purchasers with the potential to control the allocation of resources through contracts could have the ability to alter the behaviour of providers. Additionally, the system introduced by the 1990 Act which emphasised competition between providers could have altered relationships between providers. In seeking to examine whether changes had taken place the study would be engaged in the 'backward mapping' referred to above of analysing relationships between actors in the 'implementation structure'.

The second main research question was: In the light of the 1990 Act, to what extent has there been an increase in user involvement within mental health services at a local level? The study would attempt to explore, within the context of the introduction of market principles and mechanisms, whether there had been a shift from paternalism, with decisions about service planning and treatment made by managers and professionals on behalf of users, towards participation, with an increase in user consultation and involvement. This would involve investigating

the ways in which those purchasing and providing mental health services in the county had sought to realise objectives stated within local documentation of increasing user consultation and involvement and what issues and problems were associated with this. As will be discussed more fully in Chapter Four, the 1990 changes were promoted by the government of the time as offering opportunities for users to have a greater say and involvement in service planning and provision. A key objective of this research, then, was to establish to what extent these opportunities existed and had been realised at a local level within mental health services. In terms of the discussion above of the conceptualisation of social policy and approaches to its analysis, this second question can be seen more in top-down terms. Increased user involvement was portrayed by the government as one of its intended outcomes of the changes introduced by the 1990 Act. This study would aim to look at how this intention was being implemented by local level actors. This imperative from the centre is examined, however, in the research within the context of existing levels and structures of mental health user involvement within the case study county. As will be discussed more fully in Chapter Four, user involvement had also become a key theme more generally within health and social service provision. It was also identified as a priority in the case study county within local health authority purchasing and community care plans. The prominence of user involvement as an issue at both national and local level, them further justified it as key theme within the research study.

The third main research question that the study sought address was: What impact are changes in the organisation of services perceived to be having on the care and treatment that people experiencing mental health problems actually received? One of the stated intentions behind the changes introduced by the 1990 Act was to 'extend patient choice' (Department of Health, 1989a, p. 1). Given this, the study attempted to establish the extent to which it was felt that there had been any improvements in terms of users' choice and access to a range of mental health services. As Ham and Hill (1993) noted above, 'meta-policy' changes such as the

1990 Act may or may not have an effect on outcomes, in this case the services and care that people with mental health problems actually receive. To understand whether the management changes introduced by the Act have any direct effect on day to day mental health services it was felt important to consult the people that actually use those services. This last research question and its focus on user views of mental health services was also consistent with the second research question which identified user involvement as a key theme within the study. The general belief, which underpins the study, in the validity of directly consulting users of mental health services within research, is examined in more detail in Chapter Four.

Conclusion

This first section has set out the broad focus of this research study and the questions it seeks to address. It has been argued that the conception of policy analysis implicit in the research is that to understand the effect and impact of government policy intentions it is necessary to study their implementation at a local level. In doing this it has been stressed that actors involved in planning, providing and using local services will have their own perceptions of central government policy and their own priorities and concerns.

Another important assumption about social policy asserted in this chapter was that government initiatives must be not be seen in isolation but within the context of previous and existing policies. As part of this process of exploring the existing policy environment, the next chapter will examine the longer term context of mental health policy and the shift in emphasis from institutional to community care. The focus of Chapter Three is the NHS and Community Care Act 1990 and the nature of the 'market' changes it sought to introduce. Chapter Four will then examine the issue of user involvement and participation, as an important theme within the thesis, the Act and existing mental health policy and services. Chapter

Five will examine the methodological and ethical issues associated with this research. In Chapter Six the findings from the interviews with managers in the purchasing and provider organisations in the case study county will be presented. The focus of Chapter Seven is the perspectives of the professional and user interviewees in the study. Chapter Eight will then draw together the findings from the two previous chapters and discuss them in relation to the existing research. Finally, Chapter 9 will emphasise the main conclusions from the study in relation to the initial research questions as well as, examining the implications of this study for future policy and research on organisational changes affecting mental health services in the NHS.

CHAPTER TWO - BACKGROUND: CHANGES IN MENTAL HEALTH SERVICE PROVISION - FROM INSTITUTIONAL TO COMMUNITY CARE

Introduction

In the first chapter it was argued that current services and policies should not be seen in isolation but in the context of previous initiatives and developments. The next three chapters will review some of this context by focusing on three major themes in the existing literature which are of relevance to this research and the issues it seeks to address. The first of these chapters will focus on the overall development of mental health services in the twentieth century which can be characterised as a shift from institutional care in asylums to a system of community care. This has been both an important issue within mental health nationally and, as will be seen in later chapters, of considerable concern in the county used as a case study in the research. The eventual closure of a large Victorian mental hospital in the county and the reprovision of its services in the community was discussed extensively by those interviewed in the study. Services in the county were, to a large extent, still in a transition period. The last remnants of an institutional model of care, in the form of the large psychiatric hospital, were being abandoned as services attempted to embrace a community care model. As a background to subsequent chapters it is, therefore, important to examine the nature of this shift from institutional to community care.

The shift from institutional to community care

During the twentieth century the organisation of mental health services in Britain has been transformed. This can be broadly characterised as a shift from institutional to community care. The locus for the care of people with mental

health problems in the nineteenth century became the asylum[1]. Both public and private asylums were single specialist institutions set apart from the community and everyday life (Busfield, 1986). In the twentieth century asylum care has been gradually replaced by a more diverse system of services termed 'community care'. The state now funds a range of residential and non-residential mental health services. There is still both in-patient and out-patient provision in some of the old Victorian asylums but also in psychiatric units in general hospitals and community mental health centres (CMHTs). Health, social service, private and voluntary agencies provide a range of residential and day care. Domiciliary visits are undertaken by community psychiatric nurses (CPNs) and social workers, and people with mental health problems are also seen by general practitioners and other professionals in primary care settings.

The government promotion of more community based services for people with mental health problems has been traced back to the 1930s (Busfield, 1986; Hunter, 1992; Pilgrim and Rogers, 1993). The 1930 Mental Treatment Act encouraged local authorities to make arrangements for the provision of out-patient services and after care facilities for people suffering from a mental illness. Busfield (1986) noted that initially the growth in the actual provision of these types of services was relatively modest. It was also not until the 1950s that the dominance of the asylum, or the mental hospital as it had been renamed by then, began to wane. In 1954 the numbers of people resident in asylums in England and Wales peaked at 152,378 and then steadily declined (Goodwin, 1990, p.70). By 1987 the size of the resident population had fallen below 60,000 (Taylor and Taylor, 1989, p.3).

In 1961, as Minister of Health, Enoch Powell announced his plan to close the asylums in a speech to the annual conference of MIND, the National Association

[1] Since this would constitute a chapter in itself the reasons for the introduction of and the subsequent growth of asylums are not explored here. Differing explanations for the rise of the asylum system in Britain have been offered by, amongst others, Jones (1960), Scull (1979) and Busfield (1986).

for Mental Health. Yet, although provision in the asylums has steadily decreased since then, the first asylum to close (Banstead in Surrey) did not do so until 1986 (Tomlinson, 1991). By 1993, 38 of the asylums had closed and although the closure of a further 67 was planned by the year 2000, it was expected that 14 would stay open until the next century (Clark, 1993). [2]

The decline of the asylums, then, has been a long process which still continues today. Yet the general support for a system of community care has been a constant feature of statements about mental health services by successive governments since the late 1950s (Chapman *et al.*, 1991). Subsequent academic work (Goffman, 1961) and a number of scandals during the 1960s, 70s and 80s (Martin, 1985) have highlighted the neglect and paucity of life within institutions such as asylums but it was essentially in the 1950s that the decline of the asylums began (Goodwin, 1990; Rogers and Pilgrim, 1996).

This chapter focuses briefly on the competing theories which attempt to account for the shift to community care. Each of the approaches identified attempts to explain the eventual rejection of institutional care in asylums as the dominant form of mental health service provision and the growth of a more diverse range of services. As well as advancing reasons for why the move from institutional to community care took place, each explanation also carries with it implicit assumptions about the nature of the change itself and the current state of mental health services. Thus, in each case, there is both an examination of how current provision and the shift from asylum to community care is perceived and defined as well as a discussion of the reasons each theory puts forward for the shift.

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[2]These figures are from a survey carried out by researchers at Birmingham University and reported in Community Care (Clark, 1993). The research itself is not referred to since, as Milton (1995) reported, the Department of Health which commissioned the work chose not to publish its findings.

The discussion of these competing theories within this chapter is part of the essential context of mental health services and their development. These models, and the perspectives they offer, form a key part of our understanding of psychiatry in terms of its purpose, its recent history and the ways in which it has changed. The main themes of markets and user involvement within the thesis must be seen within the context of the overall shift within mental health services from institutional to community care. These theories also represent developments within social theory as each model challenges the assumptions and interpretations of previous accounts. As is discussed towards the end of the chapter, however, a criticism that can be directed to all those models is their tendency to offer broad characterisations of mental health services which neglect specific local circumstances and conditions. This thesis will attempt to counter this tendency in later chapters with its focus on the local level and the mental health services of one county in England.

Four main approaches can be identified within the literature. The first is the 'social democratic model'. The second theory is the 'Marxist account'. The third main approach is the 'post-structuralist account'. The fourth is 'Challenges to the post-structuralism'. Each approach is now considered separately before some overall criticisms and conclusions are offered.

The social democratic model

This account depicts the shift to community care as a humanitarian reform of mental health policy largely prompted by technological advances in terms of improved drug treatments for severe and enduring mental health problems. It is the representation and explanation of its origins presented within most government literature. It was exemplified by the following statement in the White Paper 'Caring for People':

> 'This policy became possible as research and clinical experience showed that treatment was equally or more effective when less reliance was placed on long term in-patient care and more use made of out-patient, day patient and domiciliary care. Additionally, more effective drug treatments, such as the major tranquillisers which were introduced in the 1950s, transformed the prognosis of the most serious mental illnesses. Where it is effectively implemented, the new style of service offers a much higher quality of life for people with a mental illness than is possible in the traditional and often remote mental hospitals. The Government reaffirms its support of the policy as a civilised and humanitarian one.' (Department of Health, 1989b, p.55)

The move away from the asylum system is depicted as 'civilised and humanitarian' and characterised as being led by advances in psychiatric practice. Increased use of out-patient, day care and domiciliary services and the availability of new drugs are all seen as contributing to the development of a system of community care.

This interpretation of the shift is also present in the work of Jones (1972) and Hunter (1992). It is claimed that :

> 'In the case of mental illness, the shift away from the long-stay hospital was, in fact, "practice-led" in the sense that newly available drugs made it possible for larger numbers of people with a mental illness to live outside hospital settings.' (Hunter, 1992, p.168)

Jones (1972) contended that the origins of community care for people with mental health problems lay within what she termed the 'pharmacological, administrative and legislative revolutions' which took place in Britain in the 1950s. Advances in psychotropic drugs in the early 1950s, Jones argued, enabled psychiatry to control some of the more extreme behaviour of those with mental health problems, thus enabling greater numbers people to live outside of the protected environment of the mental hospital. Along with this it is claimed that 'administrative' changes were taking place within mental health services. Locked wards were being opened and lengths of stays were being reduced. There was also some experimentation with new systems such as therapeutic communities, day

hospitals, social clubs and psychiatric units in general hospitals. Within these 'administrative' changes, Jones maintained that a general shift from institutional to community based patterns of care can be discerned. At the same time the state was responding to these changes within mental health services with legislative reform such as the 1959 Mental Health Act. This urged that treatment should be provided, wherever possible, on a voluntary and informal basis. It also introduced a new set of safeguards to protect patients' rights when compulsion was deemed necessary and encouraged an emphasis on community based services.

The central role given to the new drug treatments within these accounts has been widely criticised (Scull, 1977; Busfield, 1986; Goodwin, 1989; Goodwin, 1990; Pilgrim and Rogers, 1993). It has been argued that although the fall in the population of mental hospitals appears to coincide with the introduction of new forms of medication, this masks the fact that numbers had already begun to drop before the drugs became widely used. For example, Goodwin argued:

> 'The statistical evidence available in the 1950s gives no indication that the introduction of psychotropic drugs provoked any great change in the pattern of care and treatment being given by psychiatrists; rather they seem to have helped maintain a pattern already established.' (Goodwin, 1990, p.12)

Another argument against the central importance attached to these new drugs is that the policy of shifting care from an institutional base to more localised, community settings has also been applied to other groups such as elderly people and those with physical and learning disabilities. These groups are 'not deemed to be able to benefit from such drug treatment' (Pilgrim and Rogers, 1993, p.127).

Along with these empirical criticisms, this approach has also been challenged on a more theoretical level. In this account government policy and action is depicted as essentially reactive to the gradual improvements developed within psychiatry.

No consideration has been given to any interests the state may have had in advocating the run down and closure of the asylums. It is, therefore:

> 'an account that assumes an evolutionary view of society, where increasing levels of benevolence are exhibited towards disabled groups. . . . such an approach fails to adequately consider the potential importance of other, possibly less benign, motivations for the state provision of social services for mentally distressed people.' (Goodwin, 1990, p.15)

It is these 'less benign motivations' that are used as the primary explanation for the shift from institutional to community care in the account offered by Scull (1977) which is examined below.

The Marxist account

Scull (1977) adopted an essentially Marxist approach to explain the shift within mental health services from institutional care to a more dispersed community based system through reference to the overriding context of a capitalist economic structure. He interpreted the shift as, primarily, a cost cutting measure prompted by the fiscal crisis of the state. Due to economic decline in capitalist societies during the post war period, the state was increasingly seen as unable to match the demands placed upon it for public expenditure. It is argued that costs within the asylums rose after the Second World War because unpaid patient labour was eliminated and unionisation led to increased staff wage levels, shorter working days and greater holiday entitlements. Scull contends that maintaining people outside of institutions on welfare payments would have been seen by the government as a more cost-effective alternative.

The perceived cheapness of community care compared to institutional care, therefore, meant that the populations of mental hospitals were gradually moved out in order to save money. This is a process which Scull describes as 'decarceration'. Overall the account is underpinned by a contempt for the policy

shift and a condemnation of the neglect and inadequacy of current provision. Current policy is regarded as an abdication of the state's responsibilities in which people suffering from mental distress have been abandoned in the community. Scull argued that:

> 'the alternative to the institution has been to be herded into newly emerging "deviant ghettos", sewers of human misery and what is conventionally defined as social pathology within which (largely hidden from outside inspection or even notice) society's refuse may be repressively tolerated.' (Scull, 1977, p.153)

However, empirical problems have been identified within this explanation for the shift to community care (Busfield, 1986; Goodwin, 1990; Pilgrim and Rogers, 1993). Chief amongst these is the contention that the fiscal crisis of the state, which Scull argued prompted the state to endorse a policy of decarceration, was more apparent in Britain in the 1970s than it was in the 1950s. For example, Goodwin (1990) argued that after the economic difficulties of the immediate post-war period[3], the 1950s saw a period of considerable growth in the British economy. Although the economy was growing at a slower rate than in countries such the USA or Japan, 'between 1948 and 1963 Britain's economic condition appears extremely favourable' (Goodwin, 1990, p.54). As a consequence Goodwin suggested that the government was not faced with any major difficulties in raising revenue which would not have meant there was any pressing need to reduce expenditure. Goodwin argued that the mid 1970s was a period of more considerable difficulties for the British economy but by then the shift from institutional to community care had been established as government policy. Goodwin's work is examined in more detail later in this chapter.

It has also been argued that if the shift to community care was principally an attempt at cost containment then it has largely failed. Busfield (1986) contended

[3]In the winter of 1947 unemployment had risen above two million and 'war time austerity measures such as rationing and controls over industry were still very much in evidence' (Goodwin, 1990, p.53).

that with the expansion of psychiatric services outside the mental hospital there has been an increase in overall expenditure on mental health. This was not to suggest that the control of public expenditure could be dismissed as a factor in government policy formulation. What has been challenged by Busfield (1986), Goodwin (1990) and Pilgrim and Rogers (1993) is the notion of cost reduction as a primary motivation for the run-down and closure of the asylums. It has been argued that Scull merely replaced 'a technological determinist argument with an economic determinist one' (Pilgrim and Rogers, 1993, p.129).

Scull has also been criticised for concentrating on the coercive nature of mental health services and the social control function they are seen as performing in relation to the more extreme forms of mental distress. He argued that those who do not work live outside of market relationships. He contended that they have been regarded as 'deviant' and a threat to bourgeois rationality. If this 'deviancy' is labelled as 'mental illness' it can then be subject to control by psychiatric services. This has been regarded, however, as ignoring developments within psychiatry concerned with the treatment of voluntary patients and less severe mental health problems. Thus the likes of Miller and Rose (1986) and Prior (1993) have emphasised the increasing concern with so called 'milder' forms of mental illness within psychiatric discourse and practice that has been associated with the shift to community care.

The post-structuralist account

Rose (1986) rejected the account of the development of mental health services offered by Scull (1977) as economistic and crudely reductionist. It was argued that:

> 'The post-war modernization of psychiatry was a positive strategy, not a mere rationalization for financial savings. What was at stake was a new way of thinking about mental distress, a new way of linking it to social ills, and a new way of practising in relation to it.' (Rose, 1986, p.57)

Miller and Rose (1986; 1988) focused on features of psychiatric organisation which have emerged during the twentieth century such as voluntary treatment, community based services in CMHCs, primary care mental health work and more psychological approaches to dealing with mental health problems. Rose (1986) suggested that:

> 'Rather than seeking to explain a process of de-institutionalization, we need to account for *the proliferation of sites for the practice of psychiatry.* There has not been an extension of social control but rather *the psychiatrization of new problems and the differentiation of the psychiatric population . . .* '. (p. 83)

Similarly, Miller (1986) sought to avoid the 'causality' associated with previous accounts of the development of psychiatry[4]. He argued that rather than propose 'the "causes" of this or that change in psychiatry's operation', we should 'embark on the real work of untangling the complex events that go to make up the operation of a practice such as psychiatry' (Miller, 1986, p.39).

Thus he built on the work of Foucault (1961) and Castel (1976) to identify three historical periods in the development of psychiatry. The first period, from the mid-seventeenth to the end of the eighteenth century, was essentially its pre-history. This was identified by Foucault as the age of 'the great confinement' when various classes of individuals including the 'insane', the poor and the disabled began to be shut away in institutions.

The second period, from the late eighteenth century until the early decades of the twentieth century, was defined by Castel as the 'golden age' of psychiatry. This era witnessed the separation of the 'insane' from other interned groups as the

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[4]Miller and Rose (1986) used the term 'psychiatry' 'to refer to all those disciplines concerned with the troubles and disorders of conduct, emotion and thought and the conditions for mental health. It thus has a wider reference than the medical specialism.' (p.284)

profession of psychiatry emerged and claimed jurisdiction and expertise in the care and treatment of 'madness' and the 'insane' in specialised institutions.

The third period discerned by Miller, which is most relevant to this chapter, began in the early part of the twentieth century during the inter war years when psychiatry moved outside of the asylum and into the community. He contended that it was during this period that 'the neuroses were 'invented' and that child health and the family became objects for psychiatric intervention' (Miller, 1986, p. 37). From this time, both Miller (1986) and Rose (1986) argued, the remit of psychiatry was extended beyond a narrow concern with the 'insane'. A wider range of personal and social problems became construed as neuroses and therefore deemed as appropriate subjects for intervention by mental health professionals. Rose claimed that:

> 'The problem of the neuroses emerged outside both asylum and consulting room, in all those sites where individuals could be seen to fail in relation to institutional norms and expectations - the army, the factory, the school and the courts.' (Rose, 1986, p.48)

Rose contended that there had been a gradual 'transformation of madness into a problem of maladjustment, and of treatment into a technique of rehabilitation' (Rose, 1986, p. 76). He maintained that the custodialism and segregation of the asylum system with its emphasis on certification, compulsion and incarceration were seen as incompatible with this transformation.

In a similar vein, Prior (1993) argued that the changes in the organisation of mental health services which have taken place during the twentieth century 'have been intimately related to theoretical developments within psychiatry itself' (p.75). Through reference to psychiatric textbooks he argued that in the early part of the century the main objects of psychiatric practice - the brain, the nervous system, degenerate or infected bodies - were particularly suited to medical treatment in hospital settings. From the 1940s onwards, however, Prior contends

that non-physical objects of study such as personality or social and family relationships enter the domain of psychiatry. These were not especially well suited to hospital care or treatment and 'their emergence served in part to highlight the limitations of asylum care' (Prior, 1993, p.75).

Underpinning the accounts offered by Miller and Rose (1986) and Prior (1993) was a concern to offer a different interpretation than had been provided by others of the role of psychiatry and its relationship with the state. Miller (1986), for example, maintained that psychiatry should not be seen purely as an agent of the state, exercising control on its behalf. He argued that psychiatry itself had its own constitution, concerns and conditions of emergence and transformation. It should therefore be seen as an object of study in its own right rather just as a 'sub-plot to a history of the controlling power of the state' (Miller, 1986, p. 38).

Prior (1993) was critical of the 'policy orientated view' adopted by the likes of Jones (1972) and Scull (1977), which he claimed, took for granted that changes in the organisation of mental health services were the direct result of the wishes and activities of reformers and legislators. He argued that this:

> 'tends to ignore the possibility that innovations in the organization of social life often begin as the result of the unintended consequences of unplanned actions rather than of rationally calculated schemes of activity. In this respect the motives, reasons and intentions of planners can, at best, reveal only part of any evolutionary story.' (Prior, 1993, p.47-8)

However, in seeking to concentrate on psychiatry itself Miller, Rose and Prior did not consider to any great degree the role of the state and central government policy in the development of mental health services. Miller (1986), for example, noted the importance of the 1959 Mental Health Act in Britain. He argued that it 'provided an administrative framework for a psychiatry whose object would be the community and not exclusively the world of confinement' (Miller, 1986, p. 37). Yet he did not reflect on why those structures were introduced and why the

state chose to encourage a shift away from the asylums. Busfield (1986) sought to give greater consideration to the relationship between central government policy and the practice that constituted psychiatry. Goodwin (1990) attempted a more extensive examination of why successive governments since the 1950s have supported and advocated a policy of community care. Their work is considered below.

Challenges to post-structuralism

Overall Busfield (1986) argued that within mental health services there has been a shift from custodial institutions dealing with long term problems to the 'provision of services for all aspects of the patient career and all types of mental disorder' (Busfield, 1986, p. 345). Four factors are identified as explaining this shift. First, an undermining of the belief in the therapeutic value of institutions. Second, the development of non-institutional state funded welfare services and benefits. Third, increasing integration of psychiatry with the rest of medicine which led to a closer approximation to mainstream medical practice and treatment; and fourth, therapeutic innovations within psychiatry which encouraged optimism about the practicality of shorter stays in hospital and adequate out-patient care.

So like those in the previous section Busfield associated the move towards community care with a reorientation of mental health services away from chronic long-stay patients towards people with less serious, shorter-term problems. Some of the antecedents of this reorientation which she identified, however, were more closely associated with state action and initiatives. For example, she contended that the 1930 Act was important because it helped to change the perception of mental health services. It embodied and encouraged the medicalisation of psychiatry. The asylums were renamed mental hospitals and the Act encouraged greater use of voluntary admissions. Busfield contended that this helped to encourage psychiatry to move beyond its custodial role to become more

concerned with medicalised treatment and 'milder' mental health problems. The introduction of the National Health Service in 1948 was also cited as crucial in the process of integrating mental health services with mainstream medicine and other health services. Busfield's model shares much with that of the post-structuralist in identifying shifts within psychiatric discourse and practice. Her account, however, gives much greater prominence to the role of state policy and action in shaping and reacting to shifts within psychiatry. Her model depicts the shift from institutional to community care as a product of the inter-relationship between developments within the governmental and psychiatric spheres.

Goodwin (1990) also argued that there had been a shift within psychiatry from a narrow concern with 'madness' to a remit which included a wider range of mental health problems. His primary focus, however, was on central government policy formulation. He sought to take account of how advanced capitalism has influenced the nature and development of mental health policy but moving beyond what he saw as the pure structuralist approach of Scull (1977). Building on concepts developed by critical theorists Habermas (1971) and Offe (1984), Goodwin argued that mental health policy in post-war Britain was formulated according to the need to address the conflicting demands of efficiency, effectiveness and acceptability. He maintained that the precise nature of each of these pressures was inherently related to the nature of economic, societal and political circumstances at any given time.

Goodwin contended that a policy of community care was adopted and advocated by central government around the 1950s largely as a crisis management strategy. He maintained that the asylums were decaying both physically and conceptually. At that point many were almost 100 years old and a custodial model of care in institutions came to be seen as increasingly inappropriate for the treatment of a range of mental health problems including the so called 'milder' conditions. Goodwin noted that the initial government response was to embark on a plan of

improvements to existing hospitals; putting money into building repairs, improving staff levels and providing better food.

Goodwin argued, however, that this only partially addressed the competing problems of efficiency, effectiveness and acceptability. The policy of community care was adopted because it more adequately addressed these problems. In terms of efficiency, a policy of providing treatment whilst people remained in their homes or other community settings allowed the state to widen the scope of psychiatric services without providing more in-patient beds, shifting some of the cost of care to the community. It was more effective because it allowed psychiatry to extend its remit beyond the confines of the institution, allowing the treatment of a wider range of mental health problems including the 'milder' forms of mental distress. The policy also appeared more acceptable because it could be presented as a reform which decreased the role of large institutions.

Busfield and Goodwin went on from their discussions of the origins of the shift from institutional to community care to offer a similar analysis and interpretation of the development of services and the community care policy through the 1970s and 1980s. Both identified that the state's perceived fiscal crisis from the 1970s onwards prompted governments to attempt to constrain public expenditure. This resulted in a reluctance to invest more resources in welfare services. The consequence of this for mental health, they argued, has been a concentration on providing 'medically based treatment services' (Goodwin, 1990, p. 220) without adequate resourcing of other provision such as housing, social and day care services or employment opportunities. The state has also shown:

> 'renewed enthusiasm for the policy of community care, not in its initial guise of publicly funded community services but in a new guise of private care in the community. Community care now largely means care in the home, by women, and care by private and charitable agencies.' (Busfield, 1986, p. 366)

They argued that during its implementation financial concerns have contributed to a redefinition of the policy of community care. They contended that to a large extent psychiatry has divested itself of its custodial role in favour of simply providing therapeutic or medical intervention and treatment along the same lines as other specialisms in the health service. In this sense both Busfield and Goodwin emphasised what they saw as the shifting nature of community care policy. The initial drive towards community care may, in part at least, have been motivated by the desire to provide genuinely improved care and services in the community as an alternative to institutional provision. Changing economic and political circumstances, however, have meant that the investment in these alternative services has not materialised. Thus, both Busfield and Goodwin argued, the dominant focus within mental health care has become the provision of medically orientated 'treatment' to the neglect of services which would seek to address the broader social, housing and employment needs of people with mental health problems.

Discussion

Having outlined the four main approaches to explaining and interpreting the shift to community care, some additional observations will now be offered.

The different accounts and explanations for the shift within mental health services are presented above in more or less chronological order and as such they illustrate the development of social theory in general over the last twenty to thirty years. The 'social democratic model' outlined by Jones (1972) presented the shift from institutional to community care as a largely benign social reform which was the result of more enlightened attitudes to the care of those with mental health problems and improved drug treatments. The challenge to this model, based on Marxist theory and put forward by Scull (1977), represented a more critical approach to the study of social change. His account highlighted the importance of

considering both the financial motivation and consequences of closing the asylums. It also sought to emphasise what Scull saw as the subsequent neglect of those who had been 'decarcerated' from these institutions. The reductionism and narrow focus on causality within the model provided by Scull, however, was subsequently challenged by Miller and Rose (1986). Their post-structuralist account attempted a more detailed analysis of the development of psychiatry. They sought to emphasise the shift from a psychiatric discourse centred on the mind and 'madness', to one concerned with a wider range of emotional and behavioural problems. Whilst the accounts provided by Busfield (1986) and Goodwin (1990) also highlighted this shift in psychiatric discourse, their approaches also challenged the neglect of the role of the state and central government policy within post-structuralist theory. They also emphasised that the policy of community care was not static but one that had shifted with changing economic and political circumstances.

At each stage, then, these models have sought to bring different perspectives to the understanding of the development of mental health services and mental health policy. Each has also represented a challenge to the theories which have gone before it. Within each of the approaches outlined, however, there has been a failure to consider the issue of differing local circumstances within mental health service provision. All tend to offer broad characterisations of psychiatry without, to any great extent, seeming to highlight the varying patterns of development and provision in different geographical areas. A review of mental health services for adults in 12 districts in England and Wales by the Audit Commission (1994) found that the nature of expenditure and consequently provision across the districts varied. There were differences in the overall levels of expenditure on mental health care in each district. Expenditure levels were not necessarily higher in areas of social deprivation but largely based on historical patterns of spending. Those districts which at one time ran one of the large asylums tended to spend more on mental health services. Within this there were also differences in the

distribution of expenditure between different types of service. While some districts spent most of their resources on hospital beds others funded a wider range of community based and social support services. The Audit Commission's review noted that 66 per cent of the overall £1.8 billion spent on mental health care went to hospital based services. Yet, within that, certain areas did fund a great variety of provision, including services such as employment schemes, day centres and 24 hour staffed housing.

It would seem that beneath the surface of an overall national shift, the actual transition from institutional to community care at a local level is a matter of the specific circumstances in each area. In his study of the closure of Friern and Claybury hospitals in the North East Thames Regional Health Authority, Tomlinson (1991) highlighted the importance of the local context. He argued that the historical nature of provision and the relationships between different local organisations and individuals from the health, social service, housing and voluntary sector influenced both the nature of the services which were set up to replace the hospitals and how quickly they were established. For example, in one area a voluntary group was recognised by local planners as having provided good services in the past. Substantial numbers of those leaving the hospital were, then, placed in supported accommodation run by this voluntary group. However, the absence of any such provision around Banstead hospital in Surrey meant that when it was closed the majority of patients were transferred to another hospital - Horton also in Surrey (Reid and Wiseman, 1987). Such examples would seem to suggest a need for greater consideration of individual local contexts when trying to identify the nature and development of mental health services. Later sections of the thesis will attempt to give due regard to the local context by focusing, in detail, on the impact of policy developments and initiatives introduced by the NHS and Community Care Act 1990 on the mental health services of one county in England. In exploring this local context later chapters will also be able to further explore the influence of specific circumstances in the shift from

institutional to community care within mental health services. A key issue discussed with interviewees in this study was the impending closure of a large psychiatric hospital in the county called Foxton. The thesis will, therefore, seek to develop the assertion made in this chapter that due consideration should be given to specific local conditions within the examination of the shift from institutional to community care, rather than the broad approach adopted by the theories outlined above.

Conclusion

This chapter has sought to outline the overall mental health policy context against which the research must be seen. It was argued that there has been a broad shift within mental health services from the provision of care primarily in large specialist institutions to a system of community care with a range of services provided in a variety of settings. Four approaches which have attempted to explain and account for this shift were then outlined. Mirroring wider developments in social theory and analysis, each of these accounts has brought new perspectives to the understanding of the development of mental health policy. It has been noted, however, that the local context has been neglected in these accounts. The local context also plays an important role in establishing the exact nature and extent of the move from institutional to community care. This theme will be addressed further in the findings sections of this study which focus on the mental health services of one English county.

Having outlined the broad context of change in mental health service provision the next two chapters will move on to focus on the existing literature around with the two themes which are of central importance to this thesis and were highlighted in the introductory chapter. These are: the introduction of 'markets' in health care; and the role of users in mental health services.

CHAPTER THREE - MARKETS IN HEALTH CARE

Introduction

The previous chapter looked at the historical context of the development of mental health services and the shift from institutional care to community care. This chapter moves on to focus on a key policy change for mental health services as well as the health and social care sectors as a whole - the NHS and Community Care Act 1990. The 1990 Act is fundamentally important to this thesis because it introduced the 'market' mechanisms into mental health services which are a key focus within this research. As outlined in the introductory chapter one of the main themes of this study is to explore what effect the introduction of 'market' mechanisms has had on mental health services. It is, therefore, necessary to examine why and how those mechanisms were introduced under the 1990 Act.

The 1990 NHS and Community Care Act is examined in this chapter by outlining the structures it sought to introduce, the range of factors which explain its origins and finally by reviewing the research which has attempted to assess its impact. An important theme within the Act was the involvement and participation of users. This issue is analysed in detail, with a specific focus on mental health services, in the next chapter. The focus of this chapter is the 'market' changes the Act sought to introduce.

Two government White papers 'Working for Patients' (Department of Health, 1989a) and 'Caring for People' (Department of Health, 1989b) outlined the measures which became law in the 1990 Act. They set out a number of proposals for the reorganisation of the health and social service sectors respectively. Both have implications for mental health given that responsibility for this area of service provision is shared between the health and social care sectors. As mental health cuts across the health and social care divide, the field work for this thesis

included a significant number of interviewees from social services. However, in an attempt to retain a sharper focus, the study as a whole is primarily concerned with the specialist, secondary care mental health services provided by the NHS. The study still makes reference to the social service sector and also the primary health care sector (in particular the introduction of the General Practice Fundholding scheme) since the individuals and agencies within both influence developments in the secondary health care sector through joint planning, purchasing and provision of mental health services. So the changes to the primary and social care sectors are outlined and referred to in this chapter but overall the chapter concentrates on the introduction and impact of the 1990 Act in the secondary hospital and community health care sector.

The changes introduced by the NHS and Community Care Act 1990

The proposals contained in the two White Papers were passed into law in June 1990 under the NHS and Community Care Act. The changes to the NHS were implemented in April 1991 but those for the social service sector were introduced gradually in order to allow local authorities to adapt and were not fully implemented until April 1993. The Act applied to both England and Wales. Since, however, the case study county for this thesis was in England, the focus within this research is the arrangements and their implications in England.

Underpinning the changes in the 1990 Act was an attempt to introduce 'markets' of purchaser and provider agencies. The creation of separate purchaser and provider roles would mean that 'needs' for services would be assessed by purchasers who would then place 'contracts' with providers delivering services which best met those needs. Since there are differences in the main proposals set out in each of the White Papers for the health and social care sectors respectively, the first section of this chapter will, briefly examine them separately. The

remainder of the chapter, however, will then focus specifically on the health service.

Changes to the health care sector

Figure 1. sets out the broad structure and funding flows of the NHS after the introduction of the Act. It shows the split that the Act initiated between purchasers (District Health Authorities and GP fundholders) at the top and the providers (newly formed Trusts, units directly managed by District Health Authorities and the private sector) at the bottom.

One of the main changes which 'Working For Patients' (WFP) proposed for the health care sector, was concerned with the role of District Health Authorities. District Health Authorities or just Health Authorities (HAs), as they have now become known, would no longer directly be responsible for the provision of services. They were to become purchasers buying services on behalf of their local populations. The budget allocated to each HA is determined by its population size with a weighting for age, sex and social deprivation. Within these budgets HAs have to negotiate yearly contracts with agencies so that a full range of health services is provided for its population. It was envisaged that decisions about what services are contracted from providers would be based on a variety of information sources such as epidemiological data, assessments of the effectiveness of treatment procedures, as well as discussions with a range of groups and individuals such as NHS providers, voluntary organisations, Local Authorities (LAs), Community Health Councils, General Practitioners (GPs) and members of the local population. Since the introduction of the 1990 changes there have been a number of mergers of HAs such that in 1991 there were 190 HAs but by 1994 this figure had dropped to 108. Some were mergers between HAs to cover a larger population and in other cases HAs had merged with the Family Health Services Authority (FHSA) in their area which is responsible for GP services. By 1996 all

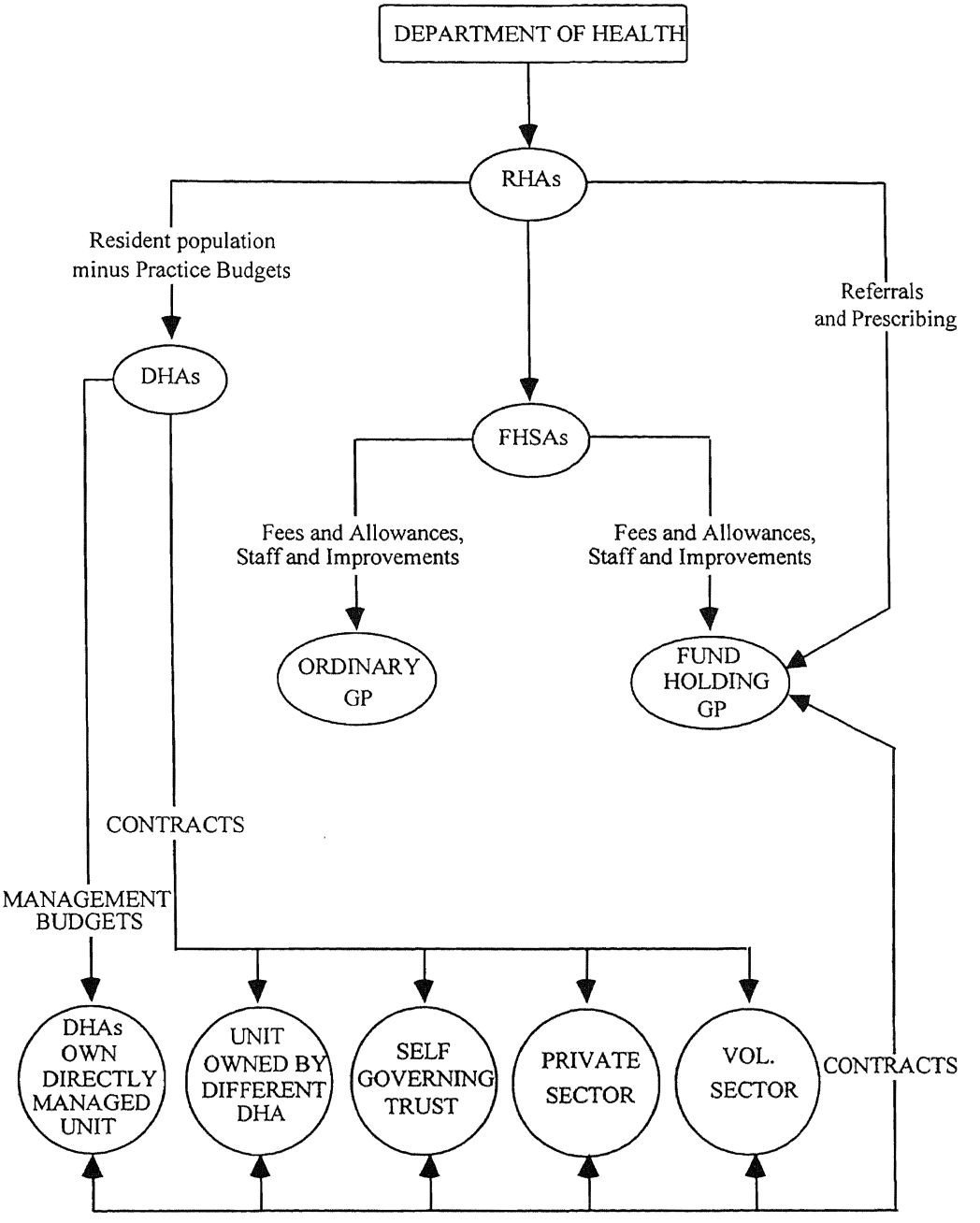

Figure 1: Major NHS funding flows 1990 (Adapted from Harrison, 1990, p. 173)

HAs and FHSAs had merged to form one organisation to purchase all hospital, community and general practitioner services for their local population (Allsop, 1995).

WFP also introduced the concept of GP Fundholders (GPFHs) to the health service. They also became purchasers, taking responsibility for a budget covering

four main elements. These were: hospital care (certain elective inpatient and day case care and most outpatient care); prescribing costs; staffing within the practice; and community services (Dixon and Glennerster, 1995a). GP practices with a patient list of more than 11,000 and an ability to demonstrate the capacity to manage their own budget were initially eligible to apply for fundholding status. The minimum patient number has since been reduced on a number of occasions and by 1995 it had dropped to 5,000. In 1995 41 per cent of the population was registered with the 10,500 fundholding practices, but with wide differences between the number of GPFHs in particular areas (Laurance, 1995). For example, by 1994, in areas such as Derbyshire and Bury 80 per cent of the population was covered by fundholding but the figure was only 4 per cent in Camden and Islington (Rivett, 1998). Table 1 above shows the increase in fundholding coverage in England since its introduction in 1991.

Table 1: GP fundholding coverage in England

Year	Coverage
1991/2	7%
1992/3	13%
1993/4	25%
1994/5	35%
1995/6	41%
1996/7	53%
1997/8	59%

From Rivett, 1998, p. 425.

The providers in the health service were to be either hospitals and community units directly managed by HAs, the private sector, voluntary agencies or newly created self-governing NHS Trusts. NHS hospitals or community units could apply for Trust status. If successful, they would then have the ability to manage their own services, raise extra capital and set their own staff wage levels. From 156 Trusts or 35 per cent of all hospital and community units in August 1992, by April 1994 the numbers had risen to 440 Trusts providing 90 per cent of all

hospital and community services (Allsop, 1995). Directly managed units or DMUs are where authority and management is retained by the health authority. Although management budgets given by HAs to DMUs would be structured as contracts they would be enforced through the normal management process (Bartlett and Le Grand, 1994) whereas the settlement of contractual disputes between purchasers and trusts would be through arbitration by the regional health authority[1] (Hughes, 1991).

Changes to the social care sector

In the social care sector the changes introduced by the government would make Social Services Departments (SSDs) the lead agency responsible for assessing the need for community care in their area and ensuring that there was adequate provision to meet that need. In consultation with other appropriate local agencies such as HAs, voluntary organisations and user and carer groups, each SSD would be expected to produce an annual Community Care Plan. They were to be seen as 'enabling authorities' stimulating a range of different services through competition amongst agencies from the public, private and voluntary sectors (Department of Health, 1989b, p.22). Providers, then, are either the SSD's own direct services, voluntary agencies, private sector organisations or housing associations.

At the individual level of users and carers, care managers purchase packages of care on their behalf using the concept of 'case management'. Ideally this should include: the full assessment and identification of the person's needs; the planning of a suitable package of services to meet those needs; monitoring of the subsequent plan and the quality of the services purchased; and a review to establish if any subsequent needs have arisen (Department of Health, 1989b).

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[1] In late 1993 the 14 regional health authorities (RHAs) were merged into eight RHAs and in 1996 these were subsequently replaced by eight regional offices of the NHS Management Executive (Allsop, 1995).

The only commitment to new resources within the changes was a 'mental illness specific grant'. This was intended to provide money for setting up new social care projects or services for people with mental health problems. In total the grant amounted to £30 million with central government providing £21 million with LAs expected to make up the remainder (Chapman et al, 1991).

Hughes (1991) identified that:

> 'The 1990 Act applies the ideology of the market to the heart of the welfare state, but does so in a way which preserves public ownership.' (p. 101)

Indeed, underpinning the proposals in both of the White papers was the notion that the introduction of market mechanisms would bring about improvements in health and social services still largely funded with public money. Competition between providers tendering for contracts would lead to improvements in terms of price and quality of services. In order to both gain and keep contracts, providers would have to keep costs down and show purchasers that they could offer quality services. A definition of a 'market' is offered by Roberts (1998):

> 'A market is an encounter controlled by supply and demand. In most markets there is a purchaser, who pays for the specific goods he or she will receive, and a seller, who has the goods and will provide them to the purchaser.' (p.186)

The markets introduced into public services such as health and social care sectors in this country differ from standard markets because they are more directly regulated by government. Government can control supply and demand by setting the expenditure levels within public services. Public sector markets have, therefore, been defined as 'quasi-markets' which are 'agent-led' (Pollitt, 1993). They are 'quasi-markets' because they are artificially created and regulated by governments. They are 'agent-led' rather than 'consumer-led' because the

consumer does not choose which services are purchased, this is done by an agent, for example, a HA or a care manager. The implications for user involvement within a system which is 'agent-led' are explored more fully in the next chapter, of which the primary focus is aspects of the 1990 Act concerned with user involvement and participation.

Having briefly outlined the nature of the changes introduced by the NHS and Community Care Act, the next section of this chapter will move on to attempt to analyse why and how these changes were introduced.

The origins of the changes

Although linked by the common theme of quasi-markets and introduced under the umbrella of a single Act of Parliament the origins of the specific changes to each of the health and social care sectors have largely received separate treatment in the literature. As mentioned previously the chief focus of this chapter and the study as a whole is on the changes in the health care sector.

Much of the literature on the origins of the NHS changes has tended to focus on specific areas. For example, Paton (1990) tended to concentrate on what could be termed the *micro-political level.* His account of the origins of the changes centred on the discussions and interactions between government ministers and civil servants in the Department of Health in shaping the nature of the measures eventually introduced by the 1990 Act. The review group, formed in January 1988 and headed by the then Prime Minister Margaret Thatcher, which came up with the proposals contained within WFP, functioned largely as a closed Cabinet committee (Butler, 1992). And as such this micro-political focus would seem justified. Yet as Hudson (1992) highlighted, precursors of the changes introduced by WFP can be seen in *developments within the health service* throughout the 1980s. Although perhaps not his specific intention, Hudson's focus on

developments within the health service itself questions the notion that the origins of the 1990 Act can be explained simply through reference to the intentions and decisions of a handful of ministers and civil servants at the micro-political level.

Beyond developments at both the micro-political and the health service levels there is another range of factors which should be considered at what can be termed the *macro-political level.* These have been identified, for example, by Allsop and May (1993) and in the work of Butler (1992, 1994), who have both highlighted the influence of New Right ideology in the changes introduced by the 1990 Act.

It is contended here that all the above levels of analysis have some role in explaining the origins of the changes introduced by the 1990 Act. In common with the discussion in the previous chapter of the origins of the shift from institutional to community care in mental health service provision, over-reliance on one level of analysis does not give an adequate account of why and how the changes were instigated. In order to provide an overall explanation the range of influences and factors at each of the three levels outlined above and the interplay between them must be considered. This approach is based on the interpretation put forward by Busfield (1986) and highlighted in the previous chapter. She argued that the development of mental health policy and practice could be explained by reference to two interrelated spheres of activities: within the health service itself; and at the state or government level. The analysis offered here of the origins of the NHS changes extends this by looking at developments within both the micro and macro level of government. In the discussion of social policy analysis in the introductory chapter of the thesis it was asserted that policies should not be seen in isolation. The examination of all the three levels of analysis outlined above, therefore, allows us to look beyond the narrow confines of the immediate origins of the 1990 Act, towards the wider context of previous developments within both the political and health service spheres.

The next section of this chapter, then, analyses the factors at each of these three levels - *the micro-political level*, *the macro-political level* and *developments within the health service* - which help to explain the origins of the changes proposed by WFP.

The micro-political level

In January 1988, whilst appearing on the BBC's Panorama programme, Margaret Thatcher announced that a major review of the NHS was already underway. Both Green (1990) and Butler (1992) suggest that this review was primarily a reaction to a crisis of public and professional confidence in the NHS during the winter of 1987-8. Their main evidence for this is twofold. First, the large amount of media coverage at the time of growing waiting lists, the temporary closure of wards and operating theatres and the denial of treatment because of lack of funds. Second, towards the end of 1987 the Presidents of the Royal Colleges of Physicians, Surgeons and Obstetricians issued a joint statement. They argued that staff morale was depressingly low and that the NHS was in desperate need of more resources. In particular, they felt that the acute hospital services had reached breaking point and urged the government to take action. Yet as Butler himself said in later work there was nothing novel about the threat of fiscal crisis in the NHS and 'the rhetoric of imminent disaster was almost as old as the service itself' (Butler, 1994, p.160). And yet why this particular flurry of attention on NHS funding should have provided such an imperative for the government to take action and announce a review of the service is not made clear.

Whatever significance has been attached to public and professional concern over the financial resources available to the health service in prompting the review, both Paton (1990) and Butler (1992, 1994) have acknowledged that its result almost entirely ignored the issue of funding. When the outcome of the review, the White Paper 'Working for Patients', appeared in February 1989, it concentrated

on the introduction of measures designed to increase the efficiency of the NHS. As previously mentioned, these mechanisms would be introduced to a system that would continue to be tax-funded and one that broadly received the same level of finance. Indeed the White Paper asserted that:

> 'It has . . . increasingly been recognised that simply injecting more and more money is not, by itself the answer' (Department of Health, 1989a, p. 3)

Instead it was contended that the organisation of service delivery needed to be reformed.

Paton (1990) stated that in the early stages of the review, the committee[2] did look at the issue of funding. They explored alternatives to the existing financing of the NHS through central taxation such as a voucher system or greater encouragement of private health insurance through tax-relief. By the late summer of 1988, however, the focus of the review had become the efficient delivery of health services. Both Paton (1990) and Butler (1994) have argued that this shift in focus can be explained by two factors. First, a change in personnel with Kenneth Clarke having taken over as Health Secretary replacing John Moore when the Department of Health and Social Security was split in two in July 1988. It is contended that Moore put forward a number of proposals for shifting to an insurance-based health service which were rejected as impractical. Kenneth Clarke in his role of junior Minister of State in the DHSS between 1982 and 1985 had been identified with initiatives around efficient 'public management', notably the Griffiths

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[2] The membership of the review committee consisted largely of senior Conservative ministers and it did not undertake a formal consultation process involving, for example, professional bodies such as the British Medical Association or the medical Royal Colleges. Instead, it sought advice from groups like the No 10 Policy Unit and 'think-tanks' such as the Centre for Policy Studies, the Adam Smith Institute and the Institute of Economic Affairs Health Unit. It also consulted individuals such as Sir Roy Griffiths (the managing director of Sainsbury, who had previously produced a report in 1983 on the restructuring of management in the NHS and since then had been Deputy Chairman of the National Health Service Board), John Redwood and David Willetts (both of whom were former members of the No 10 Policy Unit) (Paton, 1990).

Management Inquiry (Griffiths, 1983) (Paton, 1990). Second, it is suggested that Margaret Thatcher herself was wary of 'the political consequences of tampering with the financing of the service' (Butler, 1994, p. 17).

So given caution within the review over the issue of funding both Paton and Butler argued that the focus shifted to the more efficient and effective use of the existing levels of resources. The means which WFP outlined for achieving this was an internal market of purchaser and provider agencies. This was a model based on ideas set out in a paper by a visiting US economist Professor Alain Enthoven (Enthoven, 1985). The director of the Centre for Policy Studies at the time, David Willets, takes the credit for introducing his ideas to Margaret Thatcher when he showed her an article about Enthoven which appeared in The Economist (Allsop and May, 1993). Enthoven's model envisaged district general managers purchasing services for their local population from private hospitals and from the NHS in their own and other districts. It made no mention of the role of GPs as purchasers. Glennerster et al. (1994) claim that this concept was brought into the review by Kenneth Clarke. Again whilst he had been a junior minister in the DHSS in the early 1980s he was aware of the work of a group within the Department. The group had visited the United States and was struck by health maintenance organisations (HMOs) which received a premium from each of their patients and could provide treatment themselves, employ their own specialist staff or use local hospital services. The team proposed a version of the HMO idea for a Green Paper on primary care but it was rejected as too radical (Glennerster et al., 1994). Why the idea was eventually deemed acceptable within the context of WFP is not clear.

The accounts of developments at the micro-political level provided by the likes of Paton, Butler and Glennerster et al. cannot easily be contested. They give no explicit indication that they have spoken directly to any of the key players who were involved with the review of the health service. So whilst their accounts

would seem plausible much of their assertions must be taken on trust. This highlights a largely intractable problem that much of the process of policy construction in the case of WFP, as on other occasions, did not take place in the public arena.

Their accounts do, however, give us some insight (albeit limited given the closed nature of the review) into specific developments within the formulation of the changes to the health service such as the shift in the review's agenda from the issue of funding to that of the organisation of service delivery or the introduction of the GP fundholding scheme into the group's proposals. Yet these developments must not be seen in isolation and attributable solely to the outcome of discussions between a small group of government ministers, advisers and civil servants. Rather they are also rooted in longer term political considerations and a wider policy context. It is to these longer term political considerations which we now turn by examining themes and developments at the macro-political level.

The macro-political level

Although Butler (1992) argued that the review of the NHS was primarily set up in response to discontent about the funding of the health service he also suggested that it could be seen as maintaining and to some extent advancing 'the broad thrust of government policy for the public services' (Butler, 1992, p.5). Four key components to this 'broad thrust' or wider macro-political context can be identified. The first is the containment of expenditure. The second is the introduction of 'markets' into public sector services as a means of increasing their efficiency. The third is the devolution of responsibility for decision making whilst retaining central control. And the fourth is increased consumer choice. The last of these will be examined in detail in the next chapter but the first three themes are now examined briefly in turn.

Influenced by monetarist and New Right ideology, the drive to limit public expenditure was a constant theme of the Conservative administration which came to power in 1979. The central concern of the New Right has always been the economy since a 'healthy' economy is seen as the means by which the wealth and therefore the 'true' welfare of a society is ensured. 'Those on the right of the political spectrum perceived the public sector in general as a burden on the economy' (Allsop and May, 1993, p. 6) and as such a central goal of government policy since 1979 has been to limit expenditure on services like the NHS. The proposals in WFP were consistent with this objective to control spending since they did not commit the government to providing an increase in resources for the NHS.

A second consistent feature at the macro-political level is the application of the principles of the 'free market' to public sector services. The New Right has asserted the superiority of the market as a means of social organisation over that of bureaucratic planning. The work of the political philosopher Hayek (1982) was a strong influence on the ideology of the New Right (Drucker et al., 1988). Primarily proposing a critique of centralised government economic planning, Hayek argued that no one individual or group could possess sufficient information for effective planning. This information would be widely dispersed but could be embodied in the market. It could be read through market signals such as fluctuating prices which would indicate changes in supply and demand (Morrice, 1992). Hayek also believed that markets were a more 'natural' means of social interaction. He made a distinction between markets as the spontaneous or 'grown' order as opposed to planning as the organised or 'made' order. Markets, he argued, were based upon the natural inclination that people possess to compete and trade with each other. Under Conservative governments since 1979 this assertion of the supremacy of the market in the economic field has also been extended to the field of social policy. Areas of the public sector such as education, housing and the civil service have all been subject to 'market reforms'

(Le Grand and Bartlett, 1993). The measures that the NHS and Community Care Act 1990 sought to introduce can be seen as the extension of this programme to the health and social service sectors.

Citing Klein (1983), both Paton (1993) and Allsop and May (1993) have identified the changes to the NHS as consistent with a third strand of the wider political agenda. This is the tendency for politicians at the centre to want to distance themselves from responsibility for the shortcomings or inadequacies of public services at the local level whilst still retaining overall central control. Paton (1993) argued that a large degree of scepticism needs to be exercised over government claims that the changes introduced by the 1990 Act promoted devolution of power. The establishment of Trusts with responsibility for provision of services and the role of Health Authorities as purchasers in setting the overall strategic direction of local health care were presented as offering the opportunity for management and decision making to operate at the most appropriate and lowest possible level. Yet Paton contended that strong central control has still been retained through determining what level of financial resources flow to the service. He argued that centralism is also maintained through the directives that are sent out from the NHS Management Executive. So it is argued that whilst superficially ministers and politicians can claim that local level actors are responsible for any failures in the service, strong central political and financial control still remains. The influence of central directives on local level actors is a theme that is explored in later chapters in the context of the interviews with purchasers and providers of mental health services in the district used as a case study.

Linked to the themes outlined above within the wider political context and agenda, there are developments within the health service prior the 1990 changes which have been identified as precedents for the measures introduced by the NHS and Community Care Act. These are briefly reviewed below.

Developments within the health service

Hudson (1992) maintained that there were a number of 'kindred initiatives' which preceded the changes to the NHS which could be viewed as 'the framework for an "enterprise culture" and constituting a necessary prerequisite to a quasi-market' (p. 133). Chief amongst these was the enhancement of the role of management in 1984 with the implementation of recommendations of the Griffiths Management Inquiry (Griffiths, 1983). Drawing on the culture of the private sector this introduced a single general manager at the regional, district and unit levels of the NHS whose role was, broadly, to develop management plans, improve the quality of services and ensure the efficient use of resources (Allsop, 1995). The introduction of general management into the NHS was seen then by some as creating a cadre of managers who were subsequently given the responsibility of implementing and taking forward many of the changes initiated by the 1990 Act (Hudson, 1992; Butler, 1994).

Butler (1994) outlined three other developments in the NHS during the 1980s, in addition to general management which, with hindsight, can be seen as harbingers of what was to come. Firstly, he saw the introduction of income generation schemes as laying some of the foundations of a entrepreneurial and marketing culture in the NHS. Although it is argued that these schemes did not produce as much revenue as was anticipated, it did mean that for example unused corridors were filled by shopping arcades, land was sold for car parking and mail order services were set up selling things like bandages and stretchers. Secondly, the policy of contracting out was an important precursor to the quasi-market. In 1983 health authorities were required to establish competitive tendering for contracts to provide cleaning, catering and laundry services. Later this was extended to portering, transport, computing and even diagnostic and pathology services. Butler argued that this established the principle that:

> 'the core responsibility of health authorities is not to provide and manage services directly themselves, but rather to ensure that they are available when and where required at least cost to the authority and at zero cost to the patients using them' (p.15).

And thirdly, Butler argued that in addition to the growing discussion of the markets in health care in the academic and policy literature in this country and abroad, a rudimentary version of the market was in operation in London with some teaching hospitals charging District Health Authorities for services to out-of-district patients as opposed to waiting two years to be reimbursed through adjustments to their districts' financial allocation. In some ways then the 1990 Act can be seen as building on existing developments within the health service. Clearly, however, developments such as general management and competitive tendering are related to the macro-political level since they strongly reflect the influence of New Right thinking on government policy for the health service.

What this first part of the chapter has attempted to do is to set out the range of factors which each play a part in explaining the introduction of a quasi-market into the health service. No one area of focus, the micro-political, macro-political or the health service itself, entirely accounts for the changes but each contributes something to our understanding of how and why they were introduced. What is being emphasised is that the origins of the changes introduced by the 1990 Act are wider than simply a reaction by the government to media attention on problems in the health service in the winter of 1987-88. There are, by contrast, a number of precedents both within the health service itself and the government's own agenda which explain the nature of the 1990 changes and why they were introduced. Having looked at the origins of the health service changes this chapter will now move on to their implementation through reference to research which has attempted to assess their impact.

Existing research on the impact of the NHS changes

There is now a growing body of research which has studied the introduction of the changes to the NHS. In order to examine this in a perhaps more manageable way the next section initially adopts the approach taken by Robinson (1996) in his review of the research evidence on the impact of the 1990 Act. Thus this section of the chapter will discuss the research on the purchasers (both health authorities and GP fundholders), the providers and the interaction between them or the operation of quasi-markets in the NHS. In addition, the final part of this section examines the limited amount of research which has focused directly on the implications of the changes for mental health services.

Purchasers - Health Authorities (HAs)

From interviews with the General Manager and the Director of Public Health in four HAs in the summer of 1991, Harrison and Wistow (1992) found, perhaps unsurprisingly, that purchasing was still in its infancy. Although purchasers were beginning to think about setting out more explicitly what kind and range of services they were prepared to buy, at that stage much of the contracting between purchasers and providers had been in the form of 'block contracts' where the type and number of cases is only loosely specified. Therefore, there had not been any significant deviation from existing patterns of service delivery. While the lack of change could be explained by the caution of local level actors, it has also been argued that there was significant political pressure from the centre to maintain a 'steady state' (Exworthy, 1993; Hughes; 1993; Salter, 1993). In their 1991-2 contracts HAs were urged by The NHS Management Executive to ensure the continuation of existing levels of service provision and referrals. In addition, it has been suggested that initially HA purchasing was a neglected aspect of the 1990 changes. HAs were left to their own devices whilst most of the attention was on the providers and in particular the setting up of the new NHS trusts (Salter, 1993).

Since this initial 'steady state' period, however, there has been some development in the sophistication of contracts. Raftery et al. (1994) surveyed all HA contracts in England. They found that only 20% were 'block' contracts where purchasers pay providers a fixed sum for a defined range of services. The majority of contracts (62%) were 'sophisticated block' where purchasers pay providers a fixed sum for a defined range of services but with the addition of specified maximum and minimum patient activity levels as well as agreed procedures if targets are exceeded. The other main type (17%) was 'cost and volume' where the contract specifies outputs in terms of patient treatment rather than just in terms of the services provided. A fixed price is paid for a certain volume of treatment and a price per case is paid above that. The remaining 1% of contracts were 'cost per case' where a trust agrees to provide a range of specified treatments at a given contract price.

The development of HA purchasing has also been studied by researchers for the National Association of Health Authorities and Trusts (NAHAT) through the examination of all the annual purchasing plans of HAs in England (Klein and Redmayne, 1992; Redmayne et al., 1993; Redmayne, 1995; Redmayne, 1996). In common with the research discussed above their initial report in 1992 found HAs only beginning to come to grips with their new role as purchasers. A key focus of their research has been the role of HAs in prioritising or rationing services. Klein and Redmayne (1992) found HAs reluctant to choose between competing priorities and adopt an explicit rationing policy. Out of 114 HAs only 12 stated in their purchasing plans that they were going to limit the availability of specific treatments. Tattoo removal was a common example of a treatment that they would ration. In 1994 there was little change in the picture with only 11 HAs listing treatments that would be limited but in 1995 and 1996 the figures were 23 and 26 respectively. The nature of those services excluded continued to be largely cosmetic procedures (Redmayne, 1996). It was found, however, that by 1996

more HAs were using the criteria of effectiveness to justify rationing as 'evidence based medicine' was increasingly promoted within the health service. Some HAs, for example, were reducing expenditure on grommets for glue ear.

Redmayne (1996) concluded that the way that HAs had approached their purchasing role had been 'a story of gradual evolution rather than dramatic change' (p.31). In addition, it was felt that change had been very much at the edges of existing commitments. There had also been, though, a degree of local variation and experimentation. Some HAs, for example, had been examining the potential of various forms of locality purchasing, in particular attempting to involve GPs in the purchasing process.

Although the research presented above provides some indication of how purchasing has developed, the link between the evolution of purchasing and the actual services that are provided is underdeveloped. There is little indication, for example, whether the development of more sophisticated and explicit contracts means that patients or users receive improved treatment or care (in whatever way that may be defined). Also, it is unclear to what extent aims and intentions set out in purchasing plans are translated into service provision. Redmayne (1996) does seem to acknowledge this point. She highlights the fact that many purchasing plans have emphasised the need to shift services away from the acute sector towards primary care but 'hard evidence of a real shift in resources from secondary to primary care is, however, limited' (p.4).

Purchasers - General Practice Fundholders (GPFHs)

GP fundholding has been one of the most researched aspects of the NHS changes (Robinson, 1996). Reviews of the research on fundholding have now appeared (Dixon and Glennerster, 1995b; Goodwin, 1996). In attempting to look briefly at GPFH this section of the chapter will largely focus on the findings of these

reviews. GPFH is of relevance to this thesis because the fundholding budget covers some aspects of mental health - predominantly outpatient services such as appointments with psychiatrists or psychologists but also provision such as community psychiatric nursing services.

In reviewing the main published research, Dixon and Glennerster (1995b) highlighted evidence of a number of gains brought about by fundholding. They noted that several studies had found that fundholders were more successful in holding down prescribing costs than were non-fundholders. Dixon and Glennerster also found that fundholding had had an impact in terms of organisational change. A number of research studies had shown that hospital services had become more responsive to GPFHs and their patients. There had been improvements in terms of more rapid response to GP inquires, more timely and detailed discharge information, better access to some services and a shift in the power relationship between GPs and consultants.

Set against these gains, though, there were a number of areas where evidence is limited or research findings were ambiguous. For example, there was no clear evidence that the hospital referral rates of GPFHs were lower than those of other practices. And although many fundholders were offering more services, such as specialist outreach clinics, physiotherapy, counselling, dietetics and chiropody within their practices, it was not clear whether treatment is as effective or more effective in a primary care as opposed to a secondary care setting. Another area where Dixon and Glennerster found that the research was inconclusive was around transaction costs - the administrative and time costs to the NHS of providers dealing with a number of fundholders rather than a single HA purchaser. Despite much speculation and debate they also concluded that as yet there was no hard evidence that GP fundholding had led to the creation of a two tier health service with better access and treatment for the patients of GPFHs. They questioned whether fundholding had merely emphasised existing inequities between

practices. And finally Dixon and Glennerster (1995) felt that there was a lack of research around whether fundholding had led to greater choice for patients and improved quality of hospital care and treatment.

In his review of the research on fundholding Goodwin (1996) drew the same conclusions as Dixon and Glennerster (1995b) in terms of referral rates and providers' increased responsiveness to GPFHs. He also agreed that there was an ambiguity in the evidence on 'two-tierism', patient choice, quality of care, transaction costs and the effectiveness of more practice based services. Whilst he acknowledged that the early evidence had shown lower prescribing costs for fundholders he highlighted the fact that subsequent research, for example work by the Audit Commission (1996), had suggested that this was short lived.

Both reviews were critical of the existing research. Dixon and Glennerster (1995b) argued that it was uncoordinated and that much of it was methodologically weak because either a control group had not been included to contrast the experience of GPFHs against or the control group had been contaminated because it contained practices which joined the scheme later on. Goodwin (1996) also felt that generalisation was difficult since the research tended to be 'localised' to specific areas and as such fundholding may be more appropriate to some geographical areas than others.

Overall, then, both reviews concluded that despite a relatively large body of research on GP fundholding compared to other aspects of the 1990 changes, the evidence remained ambiguous to the extent to which the scheme had had a substantial positive or negative impact on services and patients. The studies on fundholding have also differed from those on HA purchasing in that the contracts between GPFHs and providers do not appear to have been a focus for research. There is, therefore, little evidence about how GPFHs may or may not contract differently from HAs. It is also unclear from the existing research, the extent to

which GPFHs have or have not shifted contracts from one provider to another and whether they have done so more, the same, or less than HAs.

Providers

Although it is argued that, in the initial stages of the implementation of the NHS changes in terms of guidance from the centre most attention was focused on the providers and the establishment of NHS trusts (Salter, 1993), there seems to be very few examples of research focused on their performance. The research that does exist centres on NHS trusts for, as Bartlett and Le Grand (1994) pointed out, directly managed units, where hospitals or community services remain under the authority and management of the health authority, are a dying breed. As indicated earlier, by 1994, 90% of all hospital and community services were provided by trusts (Allsop, 1995). This section of the chapter on providers focuses on the work of Bartlett and Le Grand (1994) who, as well as reporting on their own research, reviewed the other limited number of studies on the performance of trusts.

The empirical research reviewed by Bartlett and Le Grand (1994) has focused on three aspects of provider performance. These are: financial performance; patient activity; and operating costs. In each of these areas trusts appeared to have performed well. In their first year of operation most of the first 57 trusts met the financial performance targets relating to returns on capital, breaking even and external financing limits that had been set by the Department of Health (Newchurch, 1993). Also in the first year after the introduction of the changes two NHS Management Executive reports (NHSME, 1991, NHSME, 1992a) claimed that the increases in patient activity were greater for trusts than for directly managed units[3]. Bartlett and Le Grand's own earlier work (1992) found

[3] For trusts there was an increase of 5.4 per cent in inpatient admissions, 20.5 per cent in day cases and 8.2 per cent in total activity. The figures for DMUs were 3.8 per cent, 21.6 per cent and 6.9 per cent respectively (NHSME, 1992).

that both first wave and second wave trust applicants had lower unit operating costs than other hospitals. Bartlett and Le Grand (1994) pointed out, however, that the apparent superiority of trusts over DMUs may obscure the fact that these units were already operating more efficiently before they were granted trust status. In other words their higher levels of performance may not necessarily be the result of becoming self-governing trusts.

So the limited amount of research which has looked directly at trusts has revealed very little about whether self-governing trust status has meant increased efficiency and productivity in providing services. As both Bartlett and Le Grand (1994) and Robinson (1996) have argued, as most providers are now trusts the scope for comparing the performance of trusts and DMUs has now become limited.

The quasi-market in health care

Although again the amount of research is limited, the key issue within the interaction between purchasers and providers i.e. the nature of the quasi-market in health care, has been that of competition. Harrison and Bartlett (1993) carried out a case study of the Bristol and Weston Area where they interviewed key individuals from the HA, providers and CHCs. Based on this they concluded that it was unlikely that the quasi-market would operate in a competitive fashion in many local areas. This was because in most areas HAs would be faced with one provider and given the high start-up costs alternative providers would not be encouraged to set up.

Appleby et al. (1994), though, questioned whether the existence of local monopolies in most areas of the country had been over emphasised. Their study monitored the introduction of the market in the West Midlands and found evidence of differing local contexts and cultures. In one area there was much greater complexity and scope for competition with 40 per cent of the purchasers'

patients treated out of the district in over 30 provider units. In another area, however, the purchaser dealt only with its own district general hospital. Similarly, a teaching hospital in the study received referrals from 120 districts and another provider dealt only with its own district purchaser. The study also used a quantitative measure of competition (the Hirschman-Herfindahl index) from which they concluded that there was potential for competition amongst the 39 West Midlands acute hospitals. Overall, however, their three year study from December 1989 to December 1992 found that there had been a shift in the way that competition was perceived. They argued that the initial expectation was that the changes would introduce rigorous supply side competition into the NHS. By the end of the research, however, notions of 'managed competition' and 'contestibility' were more prominent. Managed competition meant that because those within the NHS were concerned with a number of goals other than economic efficiency such as equity of access and quality of care, government and purchasers have regulated the market to prevent trusts from collapsing as a result of the effects of market forces. Contestibility is where providers are encouraged to operate efficiently not through competition in markets on a day-to-day basis but through competition for markets at periodic stages with the threat of new entrants into the market. So there is a degree of stability in the market because providers are assured that they will hold on to contracts for a certain period of time. Competition, however, is not permanently excluded because the purchaser still retains the right to 'test' the market, for example, by inviting a range of providers to tender for a specific service or services.

Appleby et al. (1994) also emphasised the role of the local actors in the purchaser and provider organisations in determining the nature of the interaction between them and therefore the character of the local market and the extent of competition within it. This was also a theme developed by Ferlie (1994). He tested propositions derived from a review of the theoretical literature within, what Ferlie described as, the discipline of 'economic sociology' against empirical data from a

qualitative case study of an HA and an acute Trust. This involved documentary analysis, observation of meetings and interviewing of key individuals. Ferlie drew three main conclusions in his study. Firstly, the market should be seen as 'relational'. That is that interaction between purchasers and providers involved a process of continuing negotiation and displayed a complex history of adaptation, commitment, trust and conflict. Secondly, the market was 'socially embedded' meaning that there was a small elite of clinicians and managers that was maintained at the top of the purchaser and provider organisations and despite reorganisation long term careers emerged and continued. Thirdly, the market was 'institutionally embedded' or 'inward facing' in that relations between the purchaser and provider were regulated by higher tiers of the NHS with regional health authority/Management Executive outpost having arbitrated in contract disputes two years running. The complex and shifting nature of the relationship between purchasers and providers highlighted by Ferlie (1994) is emphasised in a study by Locock and Welsh (1994). In a survey of eight HAs and five GPFHs across the country they found purchasers using a variety of sanctions, incentives and threats interchangeably in their relationships with providers.

Mental health services and the changes

There have been relatively few accounts which have focused specifically on the effects of the market changes in mental health services. Both Fisher (1991) and Ward (1993) noted a possible tension between competition and the need for locally based, accessible mental health services. One of the principles of the internal market set out by the proposals in the White Paper 'Working for Patients' (Department of Health, 1989) is that competition is stimulated by having a range of providers including those in neighbouring areas. Increasingly, though, a principle within mental health services is that people should receive care in their local area in order to maintain links with their existing social networks. Purchasers, therefore, may have to contract with local providers offering a service

which is more accessible to users in favour of getting an otherwise better or cheaper service elsewhere.

Beyond this kind of general observation, it has been suggested that the perceptions and actions of actors within purchaser and provider organisations in mental health, as in other sectors of health care, play a crucial role in defining the nature of a local market in mental health. Research by Gleave and Peck (1992) drew on a series of workshops, held between 1990 and 1991, about negotiating contracts for mental health services. From this they outlined three main 'images' of the contracting process between purchasers and providers of mental health services (see Figure 2 below).

Figure 2: Images of contracting

	BUSINESS AS USUAL	**COMPETITIVE**	**COLLABORATIVE**
VALUES	ORGANISATIONAL	COMMERCIAL	CO-OPERATIVE
USER INVOLVEMENT	LITTLE	CONSUMERIST	PARTICIPANTS
ASSESSMENT	SUPPLY-LED	DEMAND-LED	NEEDS-BASED

From Gleave and Peck, 1992, p.221.

'Business as usual' represented a general opposition to the changes by some participants in the workshop and a tendency to see them as being more concerned with rhetoric than reality. This meant that although some of the language and job titles may have changed, managers would continue as normal with issues, such as increased user involvement and improved quality of services, being largely ignored. The 'competitive bidding' image was based on the expectation that the changes would transform the NHS into a competitive market place. Managers feared that their contracts may be taken over by another health, social services or voluntary sector agency and that, therefore, they would be forced to adopt a competitive stance towards other providers. The 'collaborative commissioning' model was aspired to by many who took part in the workshop and one in which

purchasers and providers worked together whilst recognising each others' different perspective. User involvement and consultation were also maximised within this 'image'.

Gleave and Peck (1992) suggest that the 'image' of contracting adopted by local actors based on their perceptions of changes may play a crucial role in defining the relationships between purchasers and providers. Based on his case study of the mental health directorate of a provider trust, Rea (1995), however, challenged the rigidity of these models. He attended fortnightly meetings of the directorate from December 1992, had access to internal documentation and interviewed key personnel. From this he argued that there was a fluidity in the way that the managers he studied perceived and engaged with other local actors and agencies involved in mental health.

> '. . responses cannot be reduced to opposition, competition, or collaboration, but will vary according to perceptions, interpretations and understandings of particular relationships' (Rea, 1995, p.153).

Rea offered a more complex analysis of relationships between actors within a managed market for mental health. In common with the account offered by Ferlie (1994) of a market in the acute health care, Rea contended that individuals used competition and collaboration interchangeably according to specific contexts and circumstances. It is this inter-relationship between organisations and actors at a local level that will be the focus of later sections of this thesis. Chapters Six, Seven and Eight will examine the findings of interviews with individuals involved in the psychiatric services of the case study county. These chapters will analyse the ways in which the interaction between actors and organisations defines the nature of the market at a local level.

Conclusion

This chapter has attempted to continue to set the context and background for later chapters which present the results from research into the market and mental health at a local level. It has outlined the nature of the market changes introduced by the NHS and Community Care Act 1990 and explored the range of factors at the micro and macro political level, as well as the precedents within the health service which all help to explain the nature of those changes and their origins.

Overall, the conclusions of the research on the market in the NHS in general and that specific to mental health services remain tentative. Researchers have attempted to evaluate the changes according to a number of criteria such as efficiency, choice, responsiveness and equity. And although some gains and losses have been identified in each of these areas, the precise impact of the changes remains unclear. One reason for this may be that even six years may be too short a time period to assess adequately the effects of widespread organisational change. It has also been suggested, however, that attempts to assess particular aspects of the changes may have been scuppered by other changes which have happened or been introduced simultaneously. For example, GP fundholding was introduced around the same time as changes to the GP contract, fundholders were given extra management allowances and other financial assistance and non-fundholding practices which could have acted as controls have been gearing up to enter the scheme themselves (Robinson, 1996). The changes were, then, introduced into an environment of existing and subsequent policy change and initiatives.

It has also been suggested that the changes themselves have been altered as they have been implemented. They have not been a set of rigid mechanisms and structures that have been adopted unquestionably by those at a local level in the health service. Studies which have taken account of this have moved beyond

descriptions and analyses based on notions of conventional economic market structure and behaviour. Instead they have developed accounts rooted in the interpretations and perceptions of actors within health care markets. Research by those such as Ferlie (1994) and Rea (1995) has shown the importance of the perceptions and interpretations of local actors and the interaction and relationships between them in shaping the nature of the local 'market' between purchasers and providers. The findings presented later on in this thesis will constitute an attempt to contribute to this developing understanding of local level interaction and relationships in the context of the 1990 NHS changes with specific reference to mental health services.

CHAPTER FOUR - USERS AND MENTAL HEALTH SERVICES

Introduction

In the last chapter four key components to the wider macro-political context of Conservative policy were identified. These were; the containment of expenditure, the introduction of 'markets' into public sector services; the devolution of responsibility for decision making; and increased consumer choice. This chapter now returns to the last of these as a major theme within the NHS and Community Care Act 1990 and looks at its implications for mental health services. As stated in the introductory chapter, user involvement is a key theme within the thesis. A specific aim of the research was to examine the extent to which the emphasis placed on user involvement within the 1990 Act was mirrored by increased user participation in mental health services at a local level. Before later chapters examine user involvement within the psychiatric services of the case study county, this chapter will provide some context to this discussion by outlining some of the theoretical debates around user involvement and reviewing the existing research on user participation in mental health services.

A wide variety of terms have been used to describe those in receipt of health and social services. They include; 'patient', 'client', 'customer', 'consumer', 'user' and a term used within the mental health field is 'survivor'. Despite concern from some individuals that the term 'user' may have drug connotations (Rogers and Pilgrim, 1991), it seems to be the most widely used term by groups and organisations of people who have had experience of mental health services and for that reason it will be the preferred term employed in this chapter and throughout this thesis. To avoid repetition, however, other terms may occasionally be used.

Beyond terminology the whole issue of the place of the user within health and social services seems to be conceptually muddled (North, 1993). One explanation

for this is that this area represents a conflation of ideas from a variety of different sources. On the one hand the NHS and Community Care Act with its New Right origins emphasised the notion of enhancing the role of service recipients as 'consumers' within the context of health and social care 'markets'. On the other hand there is now a large number of organisations which argue for the need to empower service 'users'. The roots of such assertions are generally from within calls for a more democratic and participatory form of politics and social organisation. They pre-date the emphasis of the 1990 Act on consumerism and appear to stand in contrast to its economic and market inspired notions derived from the ideas of the New Right. Though distinct the two sets of ideas, which here will be mainly referred to as 'consumerism' and 'empowerment', have acted like a 'pincer movement' within the health and social service sectors (Pilgrim, 1996). In combination they have:

> 'represented a forceful attack on what were perceived to be inefficient and insensitive bureaucracies, moulded to serve professional interests rather than the needs of clients' (North, 1993, p.130).

Both 'consumerism' and 'empowerment' then can be seen as challenges to services dominated by professional and bureaucratic interests. At a rhetorical level at least, user involvement is prominent within the health and social services and 'user views are now part of the discourse about mental health policy, both nationally and locally' (Rogers and Pilgrim, 1996, p. 163).

The first section of this chapter will examine some of the conceptual issues on users and mental health services. It will explore the nature of the challenges represented by the emphasis on 'empowerment' or 'self advocacy' by many individuals and organisations and the 'consumerist' model prominent within the 1990 changes. The specific implications and application of these concepts within mental health services will be the main focus. The second section of the chapter

will then look more directly at the existing research on users and mental health services.

Self-advocacy and empowerment

The concept of self-advocacy and empowerment as a challenge within mental health services will be examined in this first section of the chapter by briefly looking at the historical background to the growth of user-led mental health groups in Britain and then outlining the philosophies and strategies they have espoused.

> 'Psychiatry, unlike other branches of medicine, has always included an element of compulsion. Inevitably this has aroused protest and criticism. As long as psychiatry has existed, people have protested against unwanted, punitive or insensitive treatment and the social ostracism which has often gone with it.' (Read and Wallcraft, 1992, p.6)

Psychiatry has been the subject of criticism throughout its history and this has played an important role in its development. For example, the Victorian public asylums which remain a problematic legacy within today's mental health services were built in part as a response to criticism and concern over the conditions in the privately run 'madhouses' (Rogers and Pilgrim, 1996).

There are early recorded examples of protest against psychiatry such as 'The Petition of the Poor Distracted People in the House of Bedlam' in 1620 and The Alleged Lunatics Friend Society in the 1860s (Read and Wallcraft, 1992). It is not until the 1960s and 70s, however, that British organisations engaged in concerted and collective protest began to emerge. Alliances of mental health workers and users such as People Not Psychiatry and the British Network for Alternatives to Psychiatry were formed around this time. They drew on the work of psychiatrists such as Cooper (1968), Laing (1967) and Szasz (1971). Their work has often collectively been termed 'anti-psychiatry'. 'Anti-psychiatry' was

critical of three main aspects of psychiatry: the conceptual weakness of its knowledge base (for example, Szasz [1971] referred to 'the myth of mental illness'); the inappropriateness of predominately biological treatments as responses to social and existential problems; and infringements of human rights under the guise of therapeutic law (Rogers and Pilgrim, 1996).

The 1970s saw the formation of the first user-only or user-led groups, such as the Mental Patients Union and Prompt (Protection of the Rights of Mental Patients) (Read and Wallcraft, 1992). Despite gaining some media attention, these organisations did not develop and the growth of the user movement in Britain was not as extensive as in Europe and the US. For example, a national meeting of user groups held in Holland in 1977 included representatives from 35 organisations (Rogers and Pilgrim, 1991).

There was an increase in the number of mental health user groups during the 1980s. A conference run by the World Federation of Mental Health and MIND in Brighton in July 1985 has been cited as a key point in the development of the user movement in Britain (Rogers and Pilgrim, 1991; Read and Wallcraft, 1992; Morgan, 1993). It not only provided participants with the opportunity to meet with and learn from their counterparts from Italy, the Netherlands and the US but it also encouraged more links between organisations in Britain. Since 1985 there has been a rapid growth in the number of user groups (Read and Wallcraft, 1992). For example, Survivors Speak Out (SSO), which has since become one of the largest user-led organisations in Britain with over 50 local groups was formed following the conference in Brighton (Rogers and Pilgrim, 1991).

A qualitative study of some of the most influential user groups carried out by Rogers and Pilgrim (1991) demonstrated both unifying and heterogeneous features within the mental health user movement in Britain. The research involved interviews between the autumns of 1988 and 1989 with 10

representatives from organisations concerned with the empowerment of mental health users. Three key themes were reflected in the data from these interviews: ideology and policy; relationships to non-patients; and relations with agencies.

In terms of ideology and policy, the experience of having been a psychiatric patient and the subsequent need to be heard acted as a unifying feature between the members of the groups. There was also a consensus that the current state of mental health provision was not satisfactory. A three-way split philosophically, however, was identified by Rogers and Pilgrim within the movement about how people saw themselves and what they felt were the best means of addressing their needs. VOICES, a patients' group within the National Schizophrenia Fellowship (NSF) (predominantly an organisation for the relatives of those with mental health problems), used conventional terms such as 'mental illness', 'schizophrenia' and 'sufferer'. It also saw improvements in mental health care largely in terms of the more extensive provision of existing treatments and services. Other groups such as MINDLINK (a national network of users funded by national MIND) and Survivors Speak Out (SSO) rejected the label of 'mental illness' and for those thus categorised preferred the terms 'user' or 'survivor'. They were strongly critical of what they saw as an over-reliance on physical treatments such as drugs and electro-convulsive therapy (ECT) within psychiatry. Instead they emphasised the need for a greater use of 'talking treatments' and the wider availability of non-hospital based crisis services. The third more radical group included the Campaign Against Psychiatric Oppression (CAPO) which also rejects the concept of 'mental illness' and campaigns for the abolition of psychiatry as part of the struggle against the capitalist state.

There was also a variety of different views about relationships to non-patients i.e. mental health professionals and relatives. CAPO was again the most radical with regard to its views on professionals. Generally all links with professionals were eschewed because the 'psychiatric system' as a whole was seen as corrupt and

corrupting of the people who worked within it. Other groups such as SSO and MINDLINK were also critical of professionals but they did differentiate between groups. Nurses, psychologists and occupational therapists were viewed as being more open-minded and less restricted to a medical approach to mental health compared with psychiatrists. SSO and MINDLINK were also more optimistic about the potential for user organisations to find allies amongst the more radical mental health professionals than CAPO. VOICES had strong links with both professionals and relatives of those with a psychiatric diagnosis. Most of the other groups rejected close ties with relatives as they felt that users and their relatives often held opposing views.

The issue of mental health user groups and relations with other agencies concerned their views on other voluntary, health and social services organisations. All except the VOICES group were critical of the NSF. Despite its claims that it often spoke for users, NSF's perceived acceptance of the existing treatments and services offered by psychiatry was viewed with suspicion. Attitudes to MIND were more ambivalent. Although it could act as a useful resource, a tradition of paternalism was identified within the organisation. An emphasis on advocacy rather than self-advocacy was seen as distinguishing between MIND and the user-led groups in the study. Health authorities and social services departments in local authorities were recognised as having stimulated and supported user groups financially. Most groups also felt that it was important to become involved with the planning process within those health and social services organisations to represent the interests of mental health service users. There was also a recognition, however, that with only small numbers of users involved, influence may be problematic and there was a danger that users could become tokenised and marginalised within the health and social services planning process.

The growth of the number of organisations of users of mental health services has been characterised in theoretical terms as an example of the emergence of 'new

social movements' (Rogers and Pilgrim, 1991: Croft and Beresford, 1992). The gay and lesbian, black, women's, disability and environmental movements are also included in this analysis. These movements are seen as having four main common characteristics (Oliver, 1990). Firstly, they are not directly part of the traditional political process which involves the party system or single-issue pressure groups lobbying policy makers. Secondly, they offer a critical evaluation of capitalist society and favour direct social action as a means of affecting change. Thirdly, rather than focusing narrowly on material needs, their concerns are with people's wider quality of life. And finally, they tend to become internationalist because they focus on issues that cross national boundaries.

There is, though, a tension between this broad theory of 'new social movements' and its direct application to the mental health user movement. Only a few of the mental health user groups discussed earlier in this chapter would fit all of the characteristics described in the theory of 'new social movements'. The theory seems to be based on generalisations which do not fit with the diversity in ideology and approach to change adopted by the different organisations concerned with mental health service user empowerment.

Although as a radical, separatist group CAPO stands opposed to capitalism and identifies psychiatry as an intrinsic part of its oppression, it is less clear that the philosophy of groups such as MINDLINK and SSO represents a complete rejection of the current mode of societal organisation. Such groups are critical of many areas of society and the way that those with a diagnosis of 'mental illness' are excluded and marginalised. Yet such criticism does not appear to constitute a wholesale rejection of the present social, political and economic system advocated by CAPO.

Differences were also highlighted earlier in the extent to which different groups were prepared to engage with existing psychiatric services and the professionals

who work within them. Most groups argued that current mental health service provision causes rather than alleviates many of the problems faced by those experiencing mental distress. Yet there was also a realisation that user groups should try to work with professionals to try to change this. Some organisations therefore become involved in staff training and work on user-designed quality measures and outcomes for evaluating services (Evans, 1995). Such activity is seen as important since most care is provided by statutory health and social services. Alternative support structures may be set up by the most articulate and politicised mental health services users but there is also concern that:

> 'Psychiatry must be won over if the people most distressed and most damaged by the experience of breakdown are not to be left to the lions.' (Reid, 1989, p.155)[1]

The extent to which all mental health user groups are divorced from the traditional political process, as suggested by their broad characterisation as a 'new social movement', is also problematic. Whilst much of their activity may not necessarily involve engagement with the mainstream political authorities and parties at a national and local level, there still seems to be a realisation that these are important channels for attempting to effect change. For example, in 1989 a national network of 56 different mental health user groups met with opposition MPs to discuss their complaints about the nature of psychiatric services and their recommendations for changes in mental health policy (Rogers and Pilgrim, 1991). At a local level Wiltshire Community Care User Involvement Network lobbied elected members in local authorities to alter the LA's charging policy (Evans, 1995). Such examples would suggest that whilst the main focus of these groups may be on local practical action concerned with specific issues about the experience and use of mental health services, this does not preclude campaigning

[1] This quote is strangely prophetic given that amongst a spate of highly publicised tragedies involving users or ex-users of mental health services was the case of Ben Silcock who climbed into the lions' enclosure at London Zoo on New Year's Eve 1992 (Marchant, 1993).

within the wider existing political system in the same way as other longer standing organisations such as MIND or NSF.

One significant factor which has been used to explain the emergence and rise of mental health user groups during the 1980s is the hospital closure policy and shift to community care which was discussed in Chapter Two. This would appear to be specific to the psychiatric services and not apply directly to other 'new social movements' concerned with issues such as gender, race, age or the environment. The closure or scaling down of mental hospitals means that many people with a diagnosis of mental illness are now living in the community either because they have been discharged or there is less reliance on in-patient facilities. Professional and administrative power over mental health service users therefore may have become more dispersed. In addition, living in the community, people may be more likely to frame demands around their civil status (Rogers and Pilgrim, 1991). Attempts to encroach on this status have met with strong user opposition. For example, in 1988 the Royal College of Psychiatrists put forward a proposal for community treatment orders (CTOs) which would allow people to be treated compulsorily in the community. As part of the user campaign against CTOs a march through London was organised by various mental health user groups which ended with speeches and the laying of a wreath for the deceased recipients of ECT and major tranquillisers on the steps of the Royal College (Rogers and Pilgrim, 1991).

The notion of 'new social movements' may be useful for highlighting broad similarities between organisations campaigning for historically marginalised groups of people and issues. Over-emphasis on these similarities, though, may belie the diversity not only between the different movements but also between the groups within each movement. There appear to be concerns, characteristics and factors explaining their emergence which are specific to mental health user groups. It is worthwhile to note, though, for example, that the shift from

institutional to community care may also be a relevant factor for groups of people with physical disabilities or learning difficulties. The fact that, like organisations of mental health service users, many of their concerns are also centred on statutory health and social services has led to a sub-categorisation of these groups as 'new social welfare movements' (Croft and Beresford, 1992). It is also apparent that they share common objectives such as greater participation and a strong desire to speak for themselves. To allow exploration of more specific issues, concerns and events, however, a focus on mental health service users groups was retained here.

The next section explores the concept of consumerism promoted by the 1990 Act and looks at its applicability within the NHS.

Consumerism

The introduction of markets of purchasers and providers under the 1990 NHS and Community Care Act was the focus of Chapter Three. The market was designed not only to promote greater efficiency and effectiveness within services but also to 'extend patient choice' (Department of Health, 1989a, p.1) and to 'give people a greater individual say in how they live their lives and the services they need to help them to do so' (Department of Health, 1989b, p.4).

A sceptical interpretation of these statements is that they represent a 'user friendly' gloss on measures which were ostensibly aimed at increasing efficiency and controlling expenditure (North, 1991). Those involved with some of the mental health user groups referred to in the opening section of this chapter have also expressed doubts. One leading member of SSO questioned the compatibility of 'the government's concept of consumerism with the developing philosophy of self-advocacy' (Peter Campbell quoted in Herman and Green, 1991). Others have also seen the danger that the changes may be cosmetic without any real transformation in attitudes and shift in power towards service users. At the same

time however they note that 'the NHS and Community Care Act offers an opportunity for change and reassessment' (Read and Wallcraft, 1992, p.5). The attitude adopted here and in this study as a whole echoes those sentiments. Care must be taken not to accept at face value every claim made on behalf of the changes and the benefits they offer to those using services. Simply to dismiss the changes and any benefits or opportunities they may offer, however, without adequate evidence, analysis and consideration would be equally mistaken.

The model of consumerism emphasised by the 1990 health changes can be contrasted with the collective approach to empowerment adopted and advocated by the mental health user groups in the first section of this chapter. It is:

> 'an individualistic approach that attempts to achieve responsiveness to users through the introduction of a market ethos into the management and structure of the NHS.' (Mahon *et al.*, 1994, p.109)

The management inquiry into the NHS (Griffiths, 1983), identified in the last chapter as an important precursor to the 1990 changes, stressed the importance of the 'consumer' rather than the 'patient' in the health service. It asserted that the interests of the consumer should be central to every decision taken by health authorities and their management (Mahon *et al.*, 1994; Allsop, 1995). Given Griffiths' background as the managing director of Sainsbury this would seem to be a 'business' model inspired by the centrality of the customer or consumer in the private sector. Taken to its extreme this approach would envisage a consumer within the NHS making rational choices about health care in exactly the same way as he or she would about any other goods or services.

In practice, though, this model is problematic when applied to the health service in general and psychiatric services in particular. The concepts of 'exit' and 'voice' (Hirschman, 1970) have been used to illustrate the problems of directly transferring the traditional consumerist approach to the health service (Allsop,

1995) and to the social care sector (Hoyes *et al.*, 1993). Here the focus is on the health service. In the NHS people do not have the option of exit to another provider since it is a monopoly service and relatively few people can afford to use private health care. The possibilities of health service users exerting a voice is also limited since the main decisions about diagnosis and treatment are traditionally made by a medical professional based on claims to expert knowledge. There is a knowledge imbalance between users and professionals which differentiates interaction in the health service from much consumer activity elsewhere (Rogers and Pilgrim, 1996).

A further limitation of the application of a pure consumerist model within the NHS is concerned with the issue of payment and who is the purchaser. In the exchange of private sector goods and services, it is the consumer who pays. Within the NHS, however, treatment and care is largely free at the point of delivery for the individual who receives it. It is the taxpayer who funds services and since 1990 and the NHS changes a fundholding GP (GPFH) or health authority (HA) who has the responsibility for purchasing and therefore deciding which services are provided for users. The implicit assumption of GPFHs and HAs as purchasers seems to be that they would act in the best interests of users. HAs, in particular, were seen by the National Health Service Management Executive as 'champions of the people' who were encouraged to establish the needs, views and preferences of their local people and incorporate these into their purchasing decisions (NHSME, 1992b). The emphasis was, though, on members of the local population with no mention of service users (North, 1993).

The individual consumer or service user is, therefore, not the purchaser with the funds to determine what is in his or her best interests. This lack of direct influence for individual users within the changes introduced by the 1990 Act has been described as the adoption of a 'defence-industry procurement' model of competition where tenders are submitted by relatively few suppliers to provide

goods and services stipulated by a Government agency. This is radically different from a 'consumer sovereignty' model in which the paying customer can select from among a range of providers and in the process signal their approval or disapproval of the service received (Green *et al.*, 1990).

The use of compulsory admissions and treatments within mental health services also makes the consumerist model inherent within the 1990 Act particularly problematic when applied to many recipients of psychiatric services. If someone is forcibly given treatment or admitted to a psychiatric unit under the Mental Health Act 1983, it is difficult to see how they can be seen as a 'customer' who is being offered a 'service'.

> 'Mental patients themselves are arguably only the client when they opt to approach services for help.' (Rogers and Pilgrim, 1996, p. 20)

In circumstances when individuals are treated involuntarily, others could be seen as the customer or client of mental health services. Someone's relative may contact the psychiatric services in a crisis. If that person is then detained, the relative could be interpreted as being provided with a service. Similarly, if the police are alerted by members of the public, or see for themselves someone exhibiting dangerous or challenging behaviour in public then they have the power to take that person to a place of safety for psychiatric assessment. In this situation the police or the public could be seen as the clients (Rogers and Pilgrim, 1996).

From the discussion above the application of the consumerist model suggested by the 1990 Act to both the health service in general and psychiatric services in particular would seem problematic. The approach promoted by the NHS changes appears very different from that advocated by the mental health user groups discussed earlier. It has been suggested that the approach advocated by the government is a 'supermarket model of consumerism' which;

> 'emphasises customer relations but fails to address the wider issues of representation and the associated concepts of participation and empowerment.' (Mahon *et al.*, 1994, p.128)

The introduction of quasi-markets into the health and social service sectors was also greeted with unease about its likely consequences for the work of self-advocacy groups. Many of these have traditionally been funded by grants from health authorities or social services departments in local authorities. It was felt that there may be a risk that within the new system of purchasers and providers, purchasers would be prepared to pay or contract only for service provision. This would put services like advocacy under threat (Community Care Project Newsletter, 1991; Nutter, 1992). Similarly it was feared that groups of users both having an active campaigning role and being funded to provide services may be forced to concentrate on one element at the expense of the other. Such a development was viewed with apprehension because;

> 'incorporation of self-help groups within the provider sector may weaken the potential for collective representation.' (North, 1993, p.135)

In the introduction to this chapter, however, it was also suggested that the two distinct approaches 'empowerment' and 'consumerism' have acted in a 'pincer movement' (Pilgrim, 1996). Rather than being mutually exclusive, they have acted in combination to increase the profile of user issues. In both the health and social care sectors users groups may have been able to use the consumerist slant in government policy to promote their own interests (Evans, 1995; Rogers and Pilgrim, 1996).

> 'Service users in Britain have used the consumer ethos promoted by the community care legislation to establish their democratic right to participate.' (Evans, 1995)

Within the NHS a similar picture has been depicted of collectivist user groups gaining a voice in the decision making process. This has been possible both

through the emphasis on the rights of individual consumers within the last Conservative governments health policy and through alliances with managers in the NHS. Together managers and user groups have begun to attempt to challenge the authority of traditional medical elites (Rogers and Pilgrim, 1996). It is suggested that the position of the cadre of management created by the 1983 changes resulting from the Griffiths Report has been strengthened by the 1990 Act. In turn their heightened profile has created new channels of influence for user groups.

The possible alliances between managers, users and user groups is a theme which will be revisited in later sections of this thesis which examine the findings from the case study of mental health services in one county in Britain. Through reference to the views and experiences of individuals and groups within that area, the extent to which the 1990 Act has created opportunities for increased user participation in the planning and provision of mental health services in the area will be then be explored in more detail. This chapter, however, having explored some of the conceptual issues, will now look more directly at the existing research about users and mental health services.

Mental health service users and research

In looking at the existing research on users and mental health services this next section of the chapter will focus on two main areas. Firstly, it will examine the work on psychiatric users' views of services. Secondly, literature on users' participation in their own treatment and in the planning of mental health services will be examined.

In both of these areas, however, a limited amount of research has been undertaken and because of this the next section of this chapter draws repeatedly on a limited number of studies. Although in recent years there has been an increasing number

of surveys about the role of the patient in health care in general, research focusing specifically on mental health service users remains a relatively neglected area (Rogers *et al.*, 1993). Recipients of psychiatric services have frequently been the *subjects* of research but have rarely been *participants* in research. Within the medical psychiatric literature many studies have been carried out which have involved users of mental health services but in the context of developing instruments to measure their mental and social functioning. In this respect psychiatry may be no different from other areas of medical research in which emphasis is placed upon scientific method and experimental design (Rogers *et al.*, 1993). Yet the research which has been carried out involving users of health care, consulting them about their views of services, has often excluded those in receipt of psychiatric care and treatment.

The main reason which has been advanced to explain this under representation of people with mental health problems within health care research is the assumption that the views expressed by psychiatric patients will be irrational or unreliable because of the state of their minds (Dworkin, 1992; Rogers *et al.*, 1993). It is assumed that the very fact that those receiving psychiatric treatment have been given a diagnosis of 'mental illness' means that they will be incapable of expressing a 'rational' opinion. Views which are expressed by users and are critical of professionals and the services they provide have often been rejected as partial or biased. Users' opinions may also be explained by their pathology which may contain elements such as paranoia (Rogers *et al.*, 1993). There is also a genuine, albeit slightly paternalistic, concern that research involving mental health service users may arouse distress by encouraging them to recall unhappy events or experiences that people may prefer to forget (McIver, 1991).

Given that later chapters in this thesis will present findings from interviews with users of mental health services, clearly these are not assumptions which underpin this work. It is not assumed, however, that research involving people with mental

health problems is unproblematic. Some of the particular issues and considerations encountered in carrying out the interviews for this thesis will be considered in the next chapter dealing with methodological issues. This chapter, however, will now go on to explore the limited amount of research about mental health service users that has been undertaken by focusing on the two areas identified earlier; user views of mental health services, and user participation in treatment and service planning.

User views of mental health services

The research on users' views of mental health services largely shows that recipients are more critical than they are complimentary about the professional care they are offered. This stands in contrast to the overall high level of satisfaction expressed by users of NHS services for physical conditions (Allsop, 1995, p. 246). An early study, for example, focusing on the accounts of psychiatric patients and their relatives found that users preferred contact with those outside health and social services (Mills, 1962). Practitioners presumably felt they were providing services which were helpful to their clients but the 'down to earth common sense' support offered by those such as the local publican, the secretary of the local darts club and home helps, was valued above contact with mental health professionals. A later piece of work also found discrepancy between the attitudes of professionals and mental health service users in the reasons given for being in hospital (Bean, 1980). The professionals tended to view an in-patient stay in legalistic terms - whether people were admitted to hospital compulsorily or voluntarily. Users, on the other hand, felt they were there for 'a rest'.

In-patient services in particular have been the subject of considerable criticism by mental health service users. One study of user views of in-patient services found that the 'thing psychiatric patients value most about being in hospital is their

ability to leave' (McIntyre *et al.*, 1989). The other most valued aspects of in-patient life were visiting home, walking in the grounds and talking to members of staff. In another piece of research not having enough time to talk to members of staff was identified by patients as a significant area of dissatisfaction (Myers *et al.*, 1990).

Studies of the attitudes of long-stay patients after they have been discharged from mental hospitals have consistently shown a preference for living outside of hospital. A survey of 48 discharged long-stay patients involving structured interviews in the ex-patients' own home, for example, found that every respondent preferred living in the community to being in a psychiatric hospital (MacGilp, 1991). A research study, which the author of this thesis was involved with, of 19 people who had been compulsorily detained in hospital had similar findings (Reynolds *et al.*, 1995). Semi-structured interviews were carried out with the participants after they had left hospital and all respondents expressed a strong preference for community living. In a qualitative study based on interviews with 24 people with a history of mental illness, participants often expressed the view that a major cause of their lack of self-esteem was the negative experiences of hospitalisation (Barham and Hayward, 1991). They felt that hospital admission and the use of mental health services in general had resulted in them being labelled 'mentally ill'. This label resulted in a lack of self-esteem which, in their view, hindered their improvement more than any disabling effects of the mental health problems that they may have experienced.

Three problems can be identified with most of the research studies outlined above. One is that they are based on a relatively small number of respondents. The second is that they tend to be localised to a particular area or district and therefore there is no indication as to what extent such views are replicated nationally. Finally, given that most of the studies are relatively small scale, they have tended to focus on specific client groups (such as ex-long-stay patients or in-patients) or

particular areas of service provision. Subsequently gaps remain about views held by all of those people in contact with mental health services using the whole range of psychiatric services and not just in-patient services.

The above criticisms have been addressed in part by the 'People First' survey carried out by Rogers, Pilgrim and Lacy in 1993, which was commissioned by MIND in an attempt to gain a more comprehensive and systematic picture of recipients' views of mental health service provision (Rogers *et al.* , 1993; Rogers and Pilgrim, 1993). It was a national survey of 516 users about their experiences of psychiatric services in England and Wales. Respondents were interviewed by volunteers predominantly from local MIND associations but also mental health workers in other voluntary organisations and the statutory sector. The criteria for inclusion was that the person being interviewed must have had at least one period of treatment as a psychiatric in-patient. So whilst the study addresses the first two problems identified above of sample size and geographical spread, the survey does not include all the full range of people using mental health services. The inclusion criteria meant that those whose experience of mental health care was only through contact with a GP or the primary health care team, outpatient services or a member of a community mental health team would be excluded. The research for this thesis did not exclusively include those who had used in-patient mental health services. As is discussed more in the next chapter, the research sought to interview a wide range of mental health service users including those who were only using community services.

Despite these criticism, however, the research does provide the most comprehensive picture to date of user attitudes to mental health services. One of the main reasons that MIND commissioned the survey was to discover whether the kind of issues that it has campaigned on and the positions it has adopted in national debates on mental health policy are consistent with the views and concerns of those people who are receiving psychiatric care and treatment across

the country (Rogers *et al.*, 1993). The results of the survey did confirm that much of the dissatisfaction with existing service provision expressed by MIND and the majority of the mental health user groups referred to in the first part of this chapter was indeed broadly shared by users of local services. There are also consistencies with the findings of some of the smaller scale studies outlined at the beginning of this section of the chapter. For example, comments on in-patient hospital stays were overwhelmingly negative. Although the majority of users considered that their admission was necessary at the time, overall, they felt that their time as an in-patient did not make any significant contribution to addressing their underlying problems and they considered that alternatives to acute hospital units should be made available.

The survey also showed that electro-convulsive therapy (ECT) was widely rejected by users as an acceptable form of treatment. Within the qualitative data from responses to open-ended questions, however, there was evidence that some people had found it beneficial. A substantial number of the respondents were critical about drugs they had been prescribed although specific types were viewed differently. Major tranquillisers were considered to have been helpful in some way by 57 per cent of users. Of the significant minority rating them as unhelpful or harmful, the main reasons for this were side effects, their use as a form of punishment and reliance on major tranquillisers being a substitute for a lack of care by staff. Anti-depressants were generally viewed more positively than negatively with noted benefits being help with sleep, lifting of mood and engendering feelings of calm.

Non-physical treatments, such as occupational and industrial therapy, received a mixed response from users in the survey. Fifty-eight per cent found occupational therapy interesting and of those who found it uninteresting or were neutral in their response, one of main reasons put forward was a lack of choice because activities were not tailored or suited to individuals' own interests. Although only 25 per

cent of the sample reported having received industrial therapy their attitudes to it were also ambivalent. Sixty-one per cent found it helpful but detailed comments revealed criticism that tasks were often boring or repetitive and there were concerns about exploitation because of the low level of payment.

In common with one of the smaller scale surveys reviewed above (McIntyre *et al.*, 1989), the results of the People First study indicated that the majority of users value 'talk' and specific 'talking therapies' provided by a wide range of mental health professionals. Almost three-quarters of the 60 per cent of respondents who had received psychotherapy or counselling rated it positively, giving it 'the biggest vote of confidence out of all the therapies evaluated' (Rogers and Pilgrim, 1993, p. 623). 'Talking treatments' were valued by users because they felt listened to as individuals and they fulfilled the need for comfort, reassurance and concern in times of difficulty. One third of those interviewed, however, reported wanting a 'talking treatment' but being unable to obtain it.

The overall impression from the People First survey is that there is a substantial amount of dissatisfaction amongst users of mental health services. Subsequent studies, though not as extensive, have continued to support this conclusion. The review of mental health services for adults in 12 districts in England and Wales conducted by the Audit Commission (1994) found that few areas provided the services most valued by users, such as more community support and aftercare generally; more 24-hour crisis and out-of-hours facilities; the option of non-hospital crisis centres; and help with employment, benefits and finance. Fewer than 40 per cent of districts provided crisis intervention services, and fewer than 20 per cent crisis beds, respite beds and alternatives to admission. A study of users' views by The Sainsbury Centre for Mental Health confirmed the overall criticism of physical treatments reported in the People First survey and found that treatment was rated fifth in a list of the 10 most important elements of care, coming behind issues such as finance and housing (Shepherd *et al.*, 1994).

Given that studies have consistently highlighted users' dissatisfaction with much of what is provided by psychiatry it would seem fair to assume that within mental health services there has been little or no user participation in discussions about treatment options. The next section of this chapter will explore this assumption. It will analyse the research which has examined the extent to which people are involved in decisions about the treatment and services they receive.

User participation in treatment and service planning

It is notable that as part of a literature review of patient participation in psychiatric services, Glennister (1994) was not able to draw on very many British examples of research into the subject. Studies on 'immediate' participation, that is user involvement in decisions concerning their own treatment, and 'distant' participation or involvement in the planning of mental health services, are examined. Many of the studies reviewed, therefore, were carried out in America and Canada.

Users participation in treatment and specifically in their initial interview with a clinician, for example, is examined by reviewing research into first appointments in American out-patient psychiatric clinics (Eisenthal and Lazare, 1976; Eisenthal *et al.*, 1983). These studies aimed to assess the effects of a 'customer orientated' approach to initial interviews as opposed to the traditional clinician-led diagnostic approach. The 'customer orientated' approach involved people being encouraged to state a preferred treatment option before a programme of care was agreed. They discovered that users were more satisfied with their first interview when this approach was adopted. Overall, it was concluded that people preferred to have an active rather than a passive role in the initial interview and decisions about their treatment. Since users were not followed up, however, it is not clear whether their

participation in their first interview resulted in them having access to their preferred treatment option.

In the above research, despite an overall positive rating of the initial interview, little is revealed about users' satisfaction with their subsequent treatment. A recent study of user attitudes towards a 24-hour crisis intervention in Barnet showed that although two-thirds of those interviewed rated their initial crisis visit as helpful, a significant minority (40 per cent) were unhappy with the subsequent treatment or care they received (Keeble, 1997). Forty-four per cent of those who became hospital in-patients had not wanted to be admitted and 38 per cent of those not admitted had wanted to go into hospital. This dissatisfaction is, perhaps, explained by the fact that most of those interviewed (62 per cent) who could remember said they had not been asked about their preferred option for further treatment.

Another British study of 84 people with a history of severe mental health problems and their contact with their GP found that users valued attempts at greater involvement in their own treatment (Essex *et al.*, 1990). In this study users were given a written, personal record of the medical care they received. Eighty per cent appreciated being able to see what had been written about them and some felt that it gave them a greater sense of control over their own treatment and the ability to disagree with their GP. Yet it seemed that patients were only being informed about decisions concerning their treatment and the potential for users to have any influence over the nature of that treatment was not explored by the research. Glennister (1994) noted that the comment by one user that the study involved 'false democracy' was not analysed any further by Essex *et al.* (1990).

Two reports of attempts at greater user participation in the operation of psychiatric services, one in Britain (Lloyd, 1990) and the other in Canada (Quarrington, 1992) described positive effects. In the British example a psychiatric unit which had

allowed patients access to their own notes and the ability to administer their own medication reported that users took more responsibility for themselves and were more supportive to each other (Lloyd, 1990). In a rehabilitation unit for those with chronic mental health problems in Canada, the establishment of a self-help group resulted in users becoming generally more animated, assertive and showing a more 'active interest in the world around them' (Quarrington, 1992). Although positive effects on patient's behaviour were reported, neither of the above reports, though, indicated how the users themselves perceived the initiatives.

In common with the area of mental health user participation in decisions about treatment, the research specifically into psychiatric user involvement in service planning appears to be extremely limited. This is despite what seems to be a growing body of work into user participation in health and social service planning in general. The Joseph Rowntree Foundation, for example, has funded a significant amount of research into user involvement. In a report that attempted to synthesise the findings from many of these projects, however, it was noted that the Foundation has not funded many research and development projects on user involvement in mental health services (Lindow and Morris, 1995). The reasons for this are unclear but it means that to date there is a notable absence of work on mental health within the programme of a major funder of research into user involvement in this country.

The section on user involvement in service planning in the literature review by Glennister (1994) highlighted only two studies. The first was a case study of the Islington Users' Forum set up by a psychology graduate (Harris, 1989). The group was viewed by its members as having offered opportunities and the mutual support to be able to speak out. The chair of the Forum, though, questioned whether the individual who had set it up may have done too much and therefore inhibited the ability of the group to establish its own direction. The account highlighted users' desire to become actively involved in the planning of

psychiatric services but gave little indication of how successful they were in exerting an influence on mental health services in the area through the Forum.

A Canadian study co-authored by nurses and users who were members of Toronto Consumer and Family Involvement outlined three sets of barriers which prevented a shift in power from professionals to users in the decision making process within psychiatric services (Pyke *et al.*, 1991). Firstly, there were attitude barriers with professionals believing they should always be in control. Secondly, skill barriers were highlighted since users often lacked confidence and felt intimidated by professionals. And finally, users' lack of financial and clerical resources meant that there were practical barriers to greater user participation.

It seems important to stress that both these studies are accounts by participants in initiatives to increase psychiatric user involvement in service planning. Whilst they are valuable and of interest in highlighting issues and barriers in increased participation, neither is a substantive piece of research with a clear methodology and systematic attempt at data analysis.

Conclusion

Despite the emphasis on user involvement within the NHS and Community Care Act 1990 and the publication of a number of guidelines on ways of achieving greater user involvement in treatment and service planning (for example, Read and Wallcraft, 1992; Mental Health Task Force User Group, 1994), there seems to be a distinct lack of published research on user involvement in mental health services. Those studies which have examined user participation in psychiatric services have confirmed that it was welcomed by service recipients themselves but they give little indication as to what extent users have been able to have a substantial influence on either decisions about their own treatment or the wider planning of mental health services.

Later chapters of this thesis will look at the issue of user participation in both treatment and service planning by reflecting on interviews with a variety of individuals such as managers, professionals and users involved with the mental health services of one county in England. Before that, however, the next chapter will look at the methodological issues associated with carrying out and analysing these interviews. In particular, as noted earlier in this chapter, it will examine the specific issues around interviewing users of mental health services.

CHAPTER FIVE - METHODOLOGICAL ISSUES

Introduction

Before focusing on the findings from the empirical work undertaken for this study, this chapter will examine the methodological issues associated with the research. It will attempt to justify and account for the particular approach taken to data collection and analysis. It will also seek to document some of the issues, considerations and problems concerned with undertaking the study.

In examining the methodology of the research this chapter will focus on four main areas. Firstly, it will look at the justification for the adoption of a case study approach in the study. Secondly, the use of qualitative interviews as the main method of data collection will be examined. As well as looking at the debates surrounding qualitative interviews in general, the particular considerations associated with interviewing people with mental health problems will be explored. Thirdly, the ethical issues associated with the research will be examined. Finally, the approach adopted for the analysis of the data from the project will be discussed.

Each of the above areas will be explored through reference to appropriate literature on research methods and the actual experience of undertaking this particular study. Before this, however, the methods used will be briefly summarised.

Summary of methods

The empirical work for the thesis between October 1992 and May 1996 consisted of a case study of the mental health services of an English county. This particular county was chosen primarily because of a good relationship and established links

with the University of Luton. Initially, preliminary work was carried out for the research study. Meetings were arranged with 22 individuals in local statutory and voluntary organisations with an interest in mental health to gain familiarity with the particular issues and problems in the county and to discuss the best way to proceed with the research. These meetings were vital for both identifying the individuals to be interviewed in-depth and the most appropriate issues to be addressed in these interviews. These initial contacts were also invaluable for the progress of the subsequent fieldwork. By ensuring that appropriate managers and individuals within the mental health services were both aware of and had given approval for the study, the researcher found it easier to gain co-operation from those at all levels of the service. In a sensitive and political area this detailed preparatory work was vital for gaining access and trust which meant that the subsequent field work progressed smoothly.

During this preliminary period the researcher was also able to observe some of the working of managers and professionals within the mental health service. This was usually ad hoc and opportunistic but during preliminary meetings with a manager at one of the trusts, for example, a short induction programme with the service was arranged. This offered the opportunity to spend time accompanying two of the community psychiatric nurses (CPNs) from one of the community mental health teams (CMHTs) on a series of home visits. The agreement of all involved was obtained. The visits provided valuable insight into the work of the CPNs and the kind of people and problems they deal with. Gaining access to interviewees and the need to explain the research to various groups also meant being invited to a number of meetings. These were mostly the team meetings of CMHTs. The discussion of this research was often only a small part of the business of the meeting. The meetings would also include the discussion of new referrals. A strategy meeting with key individuals from one of the trusts and individuals from social services was also attended. This observation was not organised in any

systematic way and therefore does not constitute part of the data but it did provide useful background knowledge about the way services are managed and operated.

Between June 1994 and May 1996 in-depth, face to face, semi-structured, qualitative interviews, which were tape recorded, were then carried out with a total of 42 individuals in the following five groups:

- **Purchasers** - eight planning, contracting and commissioning managers from the health authority and the social services department involved in the joint planning mechanism for mental health services between health and social services in the county. These individuals were interviewed because their involvement in joint planning meant that they played a key part in the strategic management of mental health services in the county.

- **Providers** - seven individuals from the two NHS trusts providing the bulk of mental health services in the area, including chief executives, directors and managers. These individuals were selected as participants in the study because their positions in the trusts gave them key responsibility for the operational management of the local psychiatric services.

- **Voluntary and representative organisations** - three representatives from mental health voluntary and user groups in the area were interviewed because their non-statutory status could provide the research with a different perspective on mental health services.

- **Professionals** - eight professionals from the community mental health teams (CMHTs) for general psychiatry in the county dealing with people with severe and persistent neurotic and psychotic mental health problems. These were community psychiatric nurses (CPNs) and social workers. The

CMHTs were chosen as the focus for the study because they see a broad range of people with mental health problems and those using a variety of services. The users seen by CMHTs would not exclusively be using in-patient mental health services but also a range of community provision. This would allow the research to focus on wider range of services than many other previous studies which have tended to concentrate on users of in-patient provision.

- **Users** - 16 mental health service users in contact with the above community mental health teams, including both people who had been referred to the team at least three months ago and those who had been in contact with the team for over year. The different lengths of contact with services was designed to allow the study to draw on a range of different perspectives on mental health services. Both those with long and short term experience of services would be interviewed as part of the research.

Overall, the five different groups were chosen to try and gain a broad range of views and an understanding of a variety of different perspectives on mental health services in the county. More details are provided about the interviewees later in this chapter.

The purchasers, providers and voluntary and representative groups were all interviewed using the same semi-structured interview guide. Two further guides were used: one for the interviews with professionals; and another for the mental health service users. All three schedules are included in the Appendices. Throughout the research, anonymity was guaranteed to all participants in any write up of the findings from the study. It was also agreed that the location and identity of the county would not be disclosed. Ethical issues are dealt with in more detail in a later section of this chapter.

Although the tape recorded interviews were the principal means of data collection, the study also involved the collection and analysis of documents. The documentary evidence consisted of key local documentation such as the yearly purchasing plans and community care plans produced by the local health authority and social services departments respectively. The annual reports of the two trusts providing mental health services in the county were also collected. During the period that the research was carried out a Strategic Direction Statement for Mental Health (SDS) and a Hospital Closure and Reprovision Plan (HCP) for the large Victorian asylum in the area were produced in the county[1]. Access was given by the health authority to the written responses to the SDS and the HCP. These responses were sent to the purchasers by key organisations in the county with an interest in mental health services as part of the consultation process for the SDS and HCP. These proved particularly useful in understanding the reactions to the hospital closure from a wide range of individuals and groups who were not part of the interview sample. The documents were collected because they were an important means of gaining familiarity with the nature of services in the county. For example, the SDS gave a detailed break down of the mental health provision in the county at the time in terms of numbers of units, number of beds or places at each of those units, and the staffing levels of the various mental health teams.

Case study approach

This first main section of the chapter will explore the adoption of a case study approach to the research. It will outline what a case study approach is and why it was felt appropriate for this study.

Case study research involves using single or multiple examples of an area, setting or organisation to examine a particular set of questions, issues or policies. It is an established approach which has been formally defined as involving:

[1] As noted in the introductory chapter, full references for these documents are not given

> 'An empirical study that investigates a contemporary phenomenon within its real-life context, when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used' (Yin, 1989, p. 23).

Case studies can use either quantitative or qualitative data sources or both (Keen and Packwood, 1996). The case study which forms the research for this thesis used predominantly qualitative interview data and the reasons for this will be explored more fully later on in this chapter.

Yin (1989) largely defined case studies through reference to the type of issues and questions that they could be used to explore and answer. In doing so he defined three conditions which would determine whether it was appropriate to adopt a case study approach or some other method such as an experiment, a survey or a history. The first of these conditions was the type of research question posed. Although he argued that case studies were usually most appropriate for answering 'how' or 'why' questions, they could also be used for 'what' questions in exploratory research. The second condition was the degree of control the researcher has over events and actions. In researching the impact of a particular social policy, for example, the environment cannot be controlled in the same way that conditions in a laboratory can be. Researching such situations therefore requires an approach quite different from that employing an experimental design in which the influence of different variables and factors can often be 'controlled' out. The final condition was the extent to which the research focused on contemporary as opposed to historical events. Yin argued that histories are the preferred strategy when there is no access to events or the research is concerned with the 'dead' past. Case studies and surveys, however, are able to draw on current sources of evidence through observation and interviewing.

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since this would identify the county which was used as the case study in the research.

Whilst Yin set out a broad definition of what types of research might be addressed by a case study he still acknowledged that researchers may be faced with a viable choice between a case study or a survey. It is important, therefore, that this chapter should explain why a case study approach was felt appropriate in this instance. In doing so reference will be made to the three conditions set out above.

The question to be addressed by the research can be summarised overall as; what are the implications of the changes introduced by the NHS and Community Care Act for local mental health services? This is clearly a 'what' question and as noted earlier Yin would define this as appropriately answered by a case study approach if they was little previous research on the topic. Earlier chapters noted the lack of existing research on the 1990 changes and mental health services. For this reason it was decided early on a study in an under researched area such as this should focus on a specific geographical area since there was little existing knowledge on which to base and construct a more wide ranging survey. Little was known about whether the changes had any specific implications for mental health, so it was felt that it would be more appropriate to explore this in-depth in one health district.

A question arises here about the extent to which the study of the psychiatric services in one district can produce conclusions relevant to other mental health services in England. Every district in the country will have its own particular characteristics and it can be argued that the goal to find a representative area or even areas would be fruitless. The context and specific circumstances in each will differ. Later chapters will argue that the stage of development of mental health services of the district under study in terms of their continued reliance on an old Victorian asylum had consequences for the relationships between purchasers and providers. The particular situation in that area had a bearing on the implementation of the 1990 changes. The aim of a case study of one area is not

that findings can be directly transposed to other areas but that theoretical propositions that emerge may be generalisable. The point is that;

> 'the case study . . . does not represent a "sample", . . . the investigator's goal is to expand and generalize theories (analytic generalization) and not to enumerate frequencies (statistical generalization)' (Yin, 1989, p.21).

The use of a case study approach for this research can also be justified in terms of the level of control over events and actions. The changes set out in 'Working for Patients' (Department of Health, 1989) were introduced in the health service in all districts throughout the country from April 1991. This meant that there was no possibility, for example, of comparing districts which introduced the changes with those that did not. The use of 'cases' and 'controls' as in quasi-experimental research, such as randomised control trials, was clearly not practical. In addition, as a piece of government legislation to be implemented by local level officials, no researcher could have influence over when and how the changes were introduced.

The final condition which suggests the adoption of a case study approach was the extent to which the research has a contemporary focus. This study did not begin until October 1992 and as was highlighted earlier the NHS changes were introduced in April 1991. There was not, however, a single point of implementation. As will be discussed more fully in later chapters, organisations adapted to the changes and altered their roles gradually over time. The impact and effects of the changes would also not be immediate. Thus, at the start of the study and throughout the data collection, the introduction of the NHS changes remained an ongoing and contemporary issue. Those involved in and affected by the implementation of the changes were also still working in or using the mental health services of the district under study. They would still, therefore, be accessible to the researcher.

The fact that the study began after the initial implementation of the changes gave limited scope for a 'before and after' study of the impact of the 1990 Act. This was addressed to an extent, however, by the fact that many of those managing, providing and using mental health services in the district had done so before the introduction of the changes. The research, then, was able to draw on their perceptions of the extent of change brought about by the 1990 Act based on their experience before they were implemented.

Having examined why the adoption of a case study approach was felt appropriate for this research, this chapter will now go on to discuss the principal data source of qualitative interviews. It will explore why interviewing was chosen as the main data collection method and the specific approach adopted to the interview process and the selection of respondents in the study. As indicated in the previous chapter it will also look at the particular issues concerned with interviewing people with mental health problems.

Qualitative and quantitative research

It was noted earlier that case studies can employ either quantitative or qualitative research methods. In this research it was decided early on to adopt a qualitative approach to data collection and analysis, principally through the use of in-depth, semi-structured interviews. This section of the chapter will justify this decision largely in terms of the fact that the study was in an under researched area and also in terms of the issues it was attempting to examine.

As was noted in Chapter Three some of the existing research adopted the approach of examining quantitative indicators to determine how the NHS changes have operated in practice. One study had, for example, scrutinised trust performance by focusing on such things as financial indicators, patient activity, and operating costs (Bartlett and Le Grand, 1994). In the case of evaluations of GP fundholding,

researchers have collected data on referral rates to secondary care and prescribing costs (Dixon and Glennerster, 1995). Whilst these may be useful indications of aspects of the impact of the changes, a focus on these quantitative measures tells us very little about what the processes underlying these changes or what they may have meant for both those working in and using the health service. Such knowledge could be obtained by addressing those people directly.

In looking at the implementation of the changes in a local mental health service, there was little prior knowledge to be gained from the literature, however, about the impact of a purchaser/provider split on those working in and using those services. There would, therefore, have been little information on which to construct a structured quantitatively based questionnaire. Central government policy and the media debate at the start of, and indeed throughout, the research focused on issues such as 'the market', 'competition' and 'choice for consumers'. There was, however, no indication that these were meaningful concepts for those managing, providing and using mental health services. A quantitative questionnaire which asked people at length about these issues may have proved unproductive. The perceptions of those actors involved with mental health services would need to be explored first to ensure that the phrasing of questions is sensitive to their interpretation of the changes. The use of in-depth semi-structured interviews removes this need since the content and vocabulary of questions and discussion can be adapted as they are being conducted (Britten, 1996).

Beyond the practical focus on phrasing questions in such a way that they are meaningful to respondents, there was a methodological imperative to use a qualitative approach. A chief aim of the research was to examine in detail the views and experiences of people involved with mental health services rather than quantitatively measuring people's attitudes (Rogers *et al.* , 1993). The research aimed to build an account of the NHS changes and mental health services which

was rooted in an in-depth understanding of the experience of those who were directly involved with psychiatric services. The study attempted to explore these actors' 'assumptive worlds' (Ham, 1983). That is their values and beliefs about what they do within mental health services and what the changes had or would mean for them. An important aspect of this was a concern with ideology. As was explored in Chapter Three the changes had their origins in New Right ideology and as such were attempting to introduce concepts borrowed from the private sector. To this end an interesting aspect of the research would be to look at the ways in which a staunchly 'public' service such as the NHS would react to the introduction of potentially alien concepts dominant in the private sector such as 'market' and 'competition'. It seemed clear that values, beliefs and perceptions would, at this stage, be most appropriately explored with the interaction and two-way dialogue that a semi-structured, qualitative interview would allow.

The use of in-depth, semi-structured interviews as the principal method of data collection was also consistent with the overall approach to social policy analysis outlined in the introductory and reaffirmed in subsequent chapters. The assumption overall within the study is that, through implementation, actors at a local level have a vital role in shaping and defining social policy. The ways in which local level actors' interpretations of central government policy determine the nature of the services provided to users is best analysed through their perspectives and beliefs. In-depth, qualitative, semi-structured interviews allow these to be examined flexibly without prior knowledge or preconceptions. The approach adopted was also appropriate to trying to gain users perspectives on mental health services. It was asserted in the last chapter that in order to fully assess the impact of the 1990 changes it would be necessary to talk to those who actually use services. The use of a qualitative, semi-structured interviews allow users views and perspectives to be surveyed without strongly predetermining what was most important to those using services and what would be discussed in the interviews.

At this point it is important, however, to acknowledge the debate within the literature about the nature of interviewing. Much of the literature on interviewing strategy and technique portrays the process as one of gathering information which is lying dormant within respondents. The primary concern then becomes making sure that this information is valid, accurate and free from bias (Holstien and Gubrium, 1995). This interpretation has been challenged by post-structuralist, postmodernist, constructionist and ethnomethodological perspectives alike. Their approach, which is supported by this researcher, is that interviews are a social interaction in which both interviewer and respondent are actively engaged in the production of knowledge. The information about a particular topic to emerge from an interview is created by the action of interviewing itself rather than simply waiting there to be discovered by a researcher.

> 'Treating interviewing as a social encounter leads us rather quickly to the possibility that the interview is not merely a neutral conduit or source of distortion but rather the productive site of reportable knowledge itself'. (Holstien and Gubrium, 1995, p.3)

In the case of the research for this thesis there was not the assumption that the managers, professionals or users who were interviewed had an existing or pre-formed view of how the introduction of the internal market in the NHS had specifically affected mental health services. The interview itself may well have been the first time that, for example, they reflected on whether the separation brought by the NHS changes of agencies responsibilities into purchasing and providing had had any effect on previous joint working or collaboration between mental health organisations. In this sense the research was not merely 'collecting' people's' views on 'mental health and the market' but may have been actively framing those views by the questions that were asked and the discussion which took place.

Approach to interviewing and interviewee selection

The actual approach and technique adopted to conducting the interviews can be characterised as more closely resembling 'ethnographic' than 'survey' interviewing. Ethnographic interviewing has been characterised as more reflexive than the standardised nature of survey interviewing (Hammersley and Atkinson, 1983). Survey interviews, in general, have a more rigid set of questions than those employed in ethnographic interviews. Whilst an ethnographic interviewer will have a set of issues or questions that he or she will want to explore, these are used as a set of triggers to explore the views and perceptions of interviewees. These questions provide a focus for the interview as a whole but are not intended to constrain the interviewee in terms of the responses he or she gives or the areas that are deemed relevant.

A list of questions was drawn up for each of the three interviews guides in this study which are included in the appendices of the thesis. Although the interview guides contained a large number of questions, they were open so that the interviews were not directed towards the researcher's pre-conceptions about the topic as a whole and the particular issues being discussed in the interview. The questions were used as prompts for the interviewer and flexibility was employed both with regard to their wording and the order in which they were asked. As the research progressed and more familiarity and confidence were gained both with interviewing and with the issues being addressed by the research, there was less reliance on the interview guides and a greater ability to be more flexible and responsive to the interviewee. This meant that there was a greater awareness of when respondents' statements had raised issues of interest which could be linked with responses by previous interviewees or developing themes within the research as a whole.

The 22 initial encounters and meetings helped to determine both the issues to be covered in the interview guides and to determine the respondents for the 42 in-depth, tape-recorded interviews. The preliminary meetings were undertaken with managers and professionals in the health authority, the NHS trusts, social services department and individuals in the CHCs and voluntary organisations. They were set up with the assistance of supervisors and advisers both to allow greater familiarity with the structure and organisation of local mental health services and to explore the particular local issues and concerns around psychiatric provision in the area. It was these meeting which revealed the particular importance attached by those involved with mental health services to the impending closure of a large Victorian asylum in the area. These preliminary meetings also served to introduce the research, obtain access and consult about the best way to proceed with the work.

Interviews with managers

Eighteen key individuals in the statutory and voluntary agencies in the county were then approached after these preliminary meetings to take part in in-depth, semi-structured interviews which were tape recorded. Figure 3 above outlines the respondents for these interviews. The decisions about who to interview within the above groups can be characterised as 'purposive sampling' (Pope and Mays, 1996). In contrast to statistical sampling where the concern is with the representativeness of the sample in relation to a specific population, a deliberate choice of respondents was made on the basis of those who were best placed to talk about the implementation of the 1990 changes in relation to mental health. Obviously there was a concern to interview individuals from all of the main organisations with a stake in the local mental health service including those from

Figure 3: Health, social service and voluntary sector interviewees

Group	Number	Organisation	Respondents
Purchasers	4	Health authority	Strategy and planning manager Contract manager for mental health (MH) Public health consultant Consumer affairs manager
	4	Social services	Commissioning manager (East) Commissioning manager (West) MH Case manager Planning and policy manager
Providers	4	East Trust	Chief executive Director of operations Adult services manager Medical director
	3	West Trust	Chief executive Locality services manager MH services manager
Voluntary sector	1	MH user group	Chair
	1	MH voluntary organisation	Co-ordinator
	1	MH voluntary organisation	Co-ordinator
Total	18		

health and social sector purchasing and provider organisations as well as individuals from the voluntary sector. Predominantly though advice was sought

from a number of 'key informants' (Gilchrist, 1992) about the appropriate individuals to interview in the local area. The key informants were established during the preliminary meetings and these were individuals who had showed a particular interest in the research and were able to offer invaluable advice about the local context and circumstances. The main topics covered during this first 18 interviews were: overall views about the purchaser/provider split in mental health; nature of the relationships between the different local mental health agencies; the Foxton hospital closure; user involvement; and to what extent interviewees felt the 1990 changes had had a direct impact on services and users. The duration of most of these interviews was about an hour but one lasted for two hours.

Interviews with professionals

In the case of the 24 interviews with the professionals and users it was decided to approach the eight community mental health teams (CMHTs) for general psychiatry for the recruitment of respondents. These teams assist people between the ages of 16 and 64 with a wide range of mental health problems. These include both severe and persistent 'neurotic' and 'psychotic' conditions. For the most part referrals come to the teams via GPs. Since the teams were spread across the county, professionals recruited and interviewed from each would be able to draw on their experience with users from a wide variety of the different urban, suburban and rural areas in the county. In the event though one of the eight teams declined to take part in the research citing an already extensive workload as the reason. The team was based in a relatively affluent small town in the county. The fact that they did not take part in the research did not significantly affect the study's ability to reflect on the nature of mental health services across the county since one of the other teams which did agree to take part served an area with very similar socio-demographic characteristics. Of the eight professionals interviewed for the study, then, seven were members of seven of the CMHTs for general psychiatry in the county. These participants were recruited at the weekly CMHT meeting which the

researcher attended to explain the study and ask for volunteers. The final participant was a social worker at Foxton Hospital, the former large asylum in the county. As discussed in more detail in later chapters, the closure of Foxton was an important issue in the county and it was felt that it would be useful to get the perspective on mental health services of a practitioner linked with Foxton. The eight professionals interviewed consisted of four community psychiatric nurses (CPNs) and four social workers. Five were male, three were female and two of the professionals were from a minority ethnic group. On average the interviews lasted for about an hour and the main topics for the interviews with professionals were: impact of the purchaser/provider split on mental health services; users' choice of different services; user involvement; the Foxton hospital closure; relationships between the different local mental health agencies; and improvements that could be made to services.

Interviews with users

The 16 mental health service users who volunteered to take part in the study were people who were in contact with the above CPNs and social workers. An introductory letter was passed on by the professional along with a form and an envelope addressed to the researcher so that people could indicate whether they would be willing to take part in the research or not. After this initial agreement was obtained, people were then contacted to arrange a convenient time and place to carry out the interview. The location of the interview was chosen by the interviewee and in all cases respondents chose to be interviewed in their own home. The study would then be explained again to the respondents and they were asked to sign a consent form.

Recruitment of users through professionals did have the disadvantage that workers may have been able to select and steer the researcher towards people who were likely to be less critical of the service. In the event, however, this does not appear

to have been a major problem since it was found that the respondents who were interviewed were willing to be critical of both the mental health service as a whole and the individual professional they were in contact with. In addition, the decision to recruit users through professionals was taken on the basis of experience in another piece of research on user's experience of mental health services with which the researcher had been involved (Reynolds *et al.*, 1995). In that study a direct approach to a user from the researcher had caused some concern about how the project team had obtained knowledge of that person's contact with psychiatric services. It was subsequently found that a better approach was for the potential interviewee to be contacted initially by a professional who was known to them. Before contact was made by the researcher, the professional could explain the nature of the study and why the person was chosen as a potential volunteer, thereby reducing any anxieties.

Broad criteria were set about the recruitment of two different types of users from the professionals' caseload. Shorter term users were those that had been seen by the professional for at least three months but less than a year. The period of three months was used so that people would not be in the initial crisis stage of their contact with the CMHT when they may be at their most distressed and therefore unwilling or able to be interviewed. It was decided that longer term users who had been in contact with the professionals for at least a year, were also be interviewed. The inclusion of short and longer term users within this study meant that the research would address one of the criticisms made of the existing research on the views and experiences of mental health service users reviewed in Chapter Four. It was noted, for example, in Chapter Four that the criteria for inclusion in the study of users views of mental health services by Rogers *et al.* (1993) was that the participants must have had at least one period of treatment as a psychiatric in-patient. This was not a stipulation within the research for the thesis and, therefore, a broader range of users of mental health services took part in the study. This

included those who were in contact with mental health services through CMHTs but who had not necessarily spent any time as users of in-patient services.

Of the sixteen users who took part in the study, according to the criteria set out above, six were shorter term users and 10 were longer term users of mental health services. The intention had been to recruit 10 shorter term users and 10 longer term users. The recruitment of short term users, however, had proved more difficult within the time available for data collection. More shorter than longer term users declined to take part in the study when approached by professionals. It was not possible to establish why this was because people were not asked to explain why they did not want to take part in the research. This was on the grounds that, ethically, it was important that a person's decision and privacy were respected.

Table 2 outlines certain characteristics of the 16 users who were interviewed for the study. There was no noticeable bias in terms of gender and three of the interviewees were from a minority ethnic group. The study did not aim to recruit a specific target number but it was felt important that at least some respondents were from a minority ethnic group to reflect the fact that in the county as a whole there was a significant proportion of residents from minority ethnic groups.

Table 2: Characteristics of user interviewees

Gender	**Number**	**Ethnicity**	**Number**
Male	9	*White*	13
Female	7	*Minority ethnic group*	3
Total	16	**Total**	16

Although interviewees were not specifically asked their age, the overall range of ages of the users who took part in the study from early twenties to early sixties.

With most interviewees being in the 30 to 50 age range. Again the interviews lasted about an hour and the main topics covered were: extent of contact with mental health services; expectations of services; views and experiences on the services provided including choice on offer; user involvement; and any improvements that could be made to services.

Interviewing people with mental health problems

The previous chapter reviewed the existing research on user views of and participation in mental health services. It was noted that there was both a lack of previous studies and that psychiatric service users are often excluded from more general research into patients' views of services. In looking at the impact of the NHS and Community Care Act on mental health services in this study a deliberate decision was made at the outset that service users should be interviewed to gain their perspective on the changes and any effects they made have had on the services they received. The reasons for this were two fold. First, there was a strong belief that just as mental health service users should have a legitimate role in participating in decision making about services, so they had a legitimate role to play in social research about those services. Secondly, on a more practical level the full impact of the NHS changes on the mental health services of the county under study could not be assessed without reference to those people that they were actually intended to serve.

The literature on research methods has highlighted a number of obstacles to the inclusion of mental health service users in research (Dworkin, 1992; McIver, 1991). Often though this views people with mental health as a single homogeneous group but the stereotyped view of all people as dangerous and unpredictable is not justified. There is a broad range of levels of capabilities and functioning amongst those people who are labelled 'mentally ill' (Dworkin, 1992). There may be people who are too distressed or disturbed at certain stages of their

'illness' to participate in a piece of research but that does not mean they will never be able to take part in research at any point. During the empirical work for this thesis advice was taken from professionals about whether people were able to be interviewed without becoming distressed. To an extent then there was some pre-selection of people who would be more likely to be able to participate in the research. In addition, the three month criterion for short term users highlighted above meant that people who may be at an initial point of crisis and distress would not be approached. Despite the fact that people were sometimes talking about and recalling difficult and often painful problems and periods in their life, only one of the actual interviews carried out in this study proved problematic. The respondent became visibly distressed and was tearful at various points in the interview. Research involving people with mental health problems may often be avoided for the very reason that it may arouse distress by asking people to recalling difficult periods in their life (McIver, 1991). Clearly research should not add to people's distress but, for example, the respondent who became upset during an interview in this research had expressed the desire to participate in the study so there was no sense in which she was being coerced into taking part. The topics which caused distress were raised by the respondent herself, and given the opportunity to either stop the interview all together or move onto another topic, both were declined. Whilst care should be taken by researchers, people should also be allowed to make decisions themselves about whether they take part or continue to take part in research without being denied the opportunity to participate because it may cause distress.

Three other considerations have been raised with regard to research with people with mental health problems (McIver, 1992). First, there may be concern that the views expressed might not be reliable because of the person's state of mind. Second, it may be difficult to obtain a random sample since people may be reluctant to take part in surveys because they are worried about confidentiality.

Third, surveys may be problematic as users of mental health services can be difficult to trace since they frequently change addresses.

Unreliability of people's accounts due to the state of their minds did not seem to be a major problem with those people interviewed in this study. All those interviewed talked cogently and coherently about their views and experiences. Although again this may have been the result of pre-selection by professionals and exclusion of less articulate respondents, this was not made explicit to the researcher by any of the professionals involved in the study. Clearly, though, considerations about reliability are not exclusively relevant to research involving those with mental health problems.

> 'It is unrealistic to expect that interview or questionnaire data will be completely accurate, regardless of the population sampled'(Dworkin,1992, p.59).

The other two considerations of reluctance to take part because of confidentiality and the difficulty tracing people because of changing addresses again did not seem to be significant problems in this study. Some of those people who were approached to take part did decline and hence a final sample of 16 compared to an initial target of 20. Since as previously stated, however, people's privacy was respected and they were not asked for a reason for declining to be interviewed, it is not clear whether confidentiality was an issue. Making contact and arranging interviews with users was time consuming but no more so than with managers and professionals. Changing addresses was not a factor, more significant was the problem of being able to find the right time when users were at home and able to be contacted. Again though this was also a problem with managers and professionals.

Ethical issues

Although most social research raises ethical issues, it is particularly obvious with studies involving health services (Usherwood, 1996). The three main ethical issues that arise in health related research have been defined as: 'scientific validity of the research; autonomy of research participants; welfare of research participants' (Usherwood, 1996, p. 50). In conducting the research ethically with regard to these three considerations the study was aided by guidelines produced by the Faculty of Health Care and Social Studies at the University of Luton. These were themselves guided by the Social Research Association Ethical Guidelines and state that 'particular caution will be exercised in relation to research participants who are especially vulnerable, for example because of age or health, and those experiencing discrimination because of gender, (dis)ability or ethnicity' (University of Luton Faculty of Health Care and Social Studies Research Committee, 1994). It is probably true to say that particular caution was exercised in the study with regard to interviewing service users who may be vulnerable to distress. This is why in particular, as outlined above, advice was taken from professionals about whether an approach to any individual would cause distress. This also, however, had to be balanced with people's right to make their own, autonomous decisions about whether to take part in the research or not.

Since the study involved the interviewing of people using the NHS it was also essential that an application should be submitted to the relevant local research ethics committees to gain their approval. Ethical approval was granted by the two committees in the county. The process of obtaining approval proved valuable in assessing the clarity of the written information provided to users. Both the ethics committees also took a significant interest in the 'scientific' validity and design of the research. One committee in particular was keen that the sample of users interviewed should be both large enough and geographically spread over the county. When the researcher and his supervisor attended a meeting of the

committee the discussion focused mainly on this issue. The notion of statistical representativeness seemed to dominate and the committee appeared to have little experience of dealing with qualitative research. In qualitative studies, it has been argued that;

> 'sample sizes are not determined by hard and fast rules, but by other factors such as the depth and duration of the interview and what is feasible for a single interviewer.' (Mays and Pope, 1996, p.34)

The submissions to the ethics committee, however, did provide useful experience of justifying and defending the value of qualitative research to those perhaps more familiar with and used to dealing with quantitative based work.

A chief concern of ethics committees is to ensure that adequate consent will be given by those taking part in the study, particular by patients or service users. In one of the ethics committees, one member did feel that since the study involved people with mental health problems there may be a possibility that some participants would be unable to give informed consent. He was reassured, however, that by consulting with the CPNs or social workers, no individual who was unable to give his or her full consent would be approached to take part in the study. Overall the committees were satisfied with the arrangements for consent within the study. The arrangements for consent included a number of opportunities for people to decline to take part in the study and the requirement that all user interviewees should sign two copies of a consent form (one for the interviewee and one for the researcher). The consent forms included a section which explained the nature of the study and assured people of confidentiality and anonymity in the writing up and dissemination of the findings. The forms also confirmed that participants were able to withdraw from the study at any time without necessarily giving a reason and that this would not affect their care or treatment and their relationship with those that provided it.

Assurances were also given to the ethics committee, within the consent form to users and verbally to all other interviewees over the issue of tape recording of the interviews. The tapes were given a code and kept in a locked filing cabinet in the researcher's office at the University of Luton and they were only listened to by the researcher. The names and addresses of interviewees were also kept in the locked filing cabinet and participants were given an assurance that these, along with the audio tapes, would not be kept once the research had been completed. Only one participant, a social worker, did not agree to the use of a tape recorder during her interview because she did not feel comfortable being recorded. On this occasion notes were made by the researcher during the interview.

Analysis

It has been contended that;

> 'analysis of the data is not a distinct stage of the research. It begins in the pre-field work phase, in the formulation and clarification of research problems, and continues into the process of writing up'. (Hammersly and Atkinson, 1983, p. 174).

This is true of the research carried out for this thesis. For example, some analysis of the notes made from the preliminary, informal meetings at the outset of the project helped frame more specifically the overall issues that would be addressed within the tape recorded interviews. Connections between different parts of the data were also identified throughout the process of data collection. This allowed developing concepts from earlier interviews to be checked in later interviews. Notes were also made about developing ideas or theories which were then checked against the data as a whole. Yet once all 42 interviews had been carried out and transcribed there was a more formal process of analysis to be undertaken for which a strategy was established.

Within the research methods literature there seems to be a tension between two contrasting approaches to the data analysis process. First there is an attempt to outline systematic procedures which are often detailed prescriptively. There appears to an attempt to establish a 'hard scientific' rigour with suitably formal titles like 'template analysis' or 'immersion/crystallization analysis' (Miller and Crabtree, 1992). On the other hand there are those which reject this reification of scientific method (Hammersly and Atkinson, 1983). The latter approach stresses the flexible often, informal and personalised nature of data analysis. The tension between these two themes is part of the wider schism within social science between the positivists who seem to stress the need emulate 'hard science' and those who see social science as a distinct form whose strength is that everything is not reduced to definitive judgements, rules and measurement. This tension appears to be reflected in the name itself which includes both 'science' and 'social'.

The approach adopted in this study is that clearly social researchers need to be open in detailing the methods they use to analyse data. Social research should be rigorous but there is also the acknowledgement that any study will be a reflection of the personal views and perspectives of the researcher carrying out the work. The focus of the research and the analysis is chosen by the researcher and invariably reflects his or her own preconceptions. No pretence is made that the researcher is a neutral conduit simply presenting the accounts of others. In this research study the aim of the analysis was to:

> 'integrate evidence into a reasoned account. This analysis depends upon a careful dissection of data into categories which then have to be re-assembled into a 'story', taking account of regularities and variations' (Dealy, 1996, p. 166).

The 'story' in this case was that of the implementation of the NHS changes within the mental health services of the case study district between 1992 and 1996. This 'story' was constructed by piecing together the various accounts and perspectives

of those interviewed by the researcher. By drawing on multiple respondents, a picture was built up about the implementation and the impact of the 1990 changes within the mental health services in the county.

All the interviews were transcribed by the researcher into the word processing package 'Mircosoft Word' on a computer. The notes concerning emerging ideas and theories throughout the research were also written as word processor files into the computer. The computer, and specifically the word processing package, was used as a tool for 'dissecting the data into categories'. Three stages have been outlined in using word processors in the management of text data in the analysis process (Reid, 1992).

The first stage is data preparation and this involves initial entry of text data. In the case of this study that meant the process of transcribing the interviews and the entry of field notes, observations and ideas into the computer.

The second stage is that of data identification where the text data is divided into 'analytically meaningful and easily locatable segments' (Reid, 1992, p.126). An example of this can be given from the current study. In the case of the first group of 18 research subjects (those from the purchaser, provider and voluntary sector organisations) the interviews would often begin with a question about what people felt were the advantages of the purchaser/provider split for mental health services. All responses to this or a similar question were then group into a new word processor file called 'Advantages'. This could then be examined for common themes. In the case of the user interviews individuals were usually asked about the extent to which they felt that they were given or could express a choice about the services and support they were offered. Again the responses to this issue could be grouped into a new file called 'Choice'.

The final stage of the process is data manipulation involving searching the data for particular words, phrases or segments which are then retrieved and sorted. In the example of the 'Advantages' file noted above, one respondent mentioned that a benefit of the purchaser/provider for mental health services had been that it had allowed the organisations to clarify their roles and 'decide what business they were in'. The text search functions of the word processor could then be used to examine the rest of the file by doing searches on words such as 'clear', 'clarity' and 'role' or 'roles'. The particular word processor package being utilised also had the facility to carry out word searches on groups of files. By copying all the interview transcripts and research notes into one folder or directory, the data as a whole could then be searched for the above phrases. The findings of these searches were then able to be used to build up a picture of common themes and concepts between the accounts provided by respondents.

It must be stressed that overall the computer and word processing package were merely used as tools. The analysis was still clearly being done by the researcher. In addition, although a useful function, care was taken not to be over-reliant on the word search function. It ultimately does not have the sophistication to recognise similar concepts or words which may have been expressed differently by respondents using different vocabulary. While this can be overcome to an extent by searching on a variety of alternate words and phrases there was no substitute for familiarity with the data overall by repeatedly reading transcripts in their original and complete form. Care had to be taken not to focus on individual words and phases at the expense of overall meaning and the context in which those phrases were expressed.

Overall critique of the methods used in the study

To conclude this chapter, this section will provide a critical appraisal of the methodology used in this study. It will review the main strengths and weaknesses

of the approach adopted, as well as indicating why other design options were rejected.

Weaknesses of the study

A principal weakness of the research for this thesis was that it consisted of a case study of only one county. This means that the study can claim limited generalisability for its empirical findings. Though, as discussed earlier, this does not preclude the production of theoretical propositions which may be generalisable (Yin, 1989). The impact of the 1990 Act on mental health services of other counties may have been very different from that of the county chosen as a case study within this research. This problem, however, would have remained with a study of two, three or four areas. Given different local contexts and circumstances there would be no guarantee that these areas would be representative of all those in the country.

An alternative methodology could have been a survey of all health authority areas in England. Given resource and time limitations, it would probably not have been feasible to interview more than one respondent in each of the 108 health authority areas. More structured postal questionnaires would perhaps have been possible but this would have required a prior knowledge of the most important issues and questions which was not available to the researcher given the lack of existing studies on this particular topic area.

The smaller range of respondents within a more wide ranging survey would have sacrificed an important strength of this study, namely the triangulation of responses from individuals from different organisations and backgrounds. By focusing on one county the study was able to interview a wide range of representatives from a number of different mental health organisations (health, social service, voluntary and user agencies), as well as those from different levels

within the psychiatric services (managers, professionals and users). This has given the study a broader understanding of the local context from a variety of different perspectives. The inclusion of a broad range of respondents was also consistent with the 'backward mapping' approach to policy analysis discussed in Chapter One which aims to examine in detail the local 'implementation structure' from the 'bottom-up'.

A disadvantage of interviewing this broad range of respondents face to face, however, is that the setting up and carrying out the interviews can be very time consuming in comparison to, for example, postal questionnaires. Postal questionnaires may have had been superficial in their examination of the subject area. In addition, in such a politically sensitive area as the introduction of new structures and roles in the NHS, there may have been a reluctance to respond to a postal questionnaires and those responses that were received may have been fairly anodyne. Within the in-depth case study of one county, the researcher was given able to build up a degree of trust which resulted in an openness from participants that would perhaps not have been possible within a more wide ranging survey.

Another possible criticism of the study is that in seeking to assess whether the 1990 Act had resulted in any changes within the mental health services in the county, it relied on subjective opinions of change rather than, for example, more 'objective' indicators of change in patterns of service organisation or use. Staffing numbers, numbers of in-patient admissions or out-patient referrals from GPs could have been used as proxies for determining changes in mental health services. Knowledge of what specific data to collect, though, would have required prior information about the likely impact of the 1990 Act. The impact of the changes, however, were not easily predictable.

Even if the study had shown any change in relation to variables such as hospital admissions or referrals, such measures would not have been appropriate for

answering the research questions the study was seeking to address. The three research questions outlined in Chapter One on the impact of the 1990 changes are essentially concerned with the experience of those planning, providing and using local mental health services. Quantitative measures of service usage and provision would reveal little of that experience. They were more appropriately discovered by addressing those people directly and the use of qualitative methods allowed greater depth and flexibility in exploring these largely unresearched issues. The first research question was concerned with the impact of the 1990 changes on local mental health actors and the relationships between them. Indications of levels of service provision would not have given much indication of this. The second research question was concerned with the level of user involvement at a local level after the 1990 Act. Again, to address this issue it was necessary to consult directly with those organisations with a stake in user involvement in the county. The final research question was concerned with users' experiences of mental health services after the 1990 Act. Clearly the best way to ascertain this was to contact users themselves and the advantage of face to face qualitative interviews was that they did not necessarily pre-judge the views of respondents by restricting them to closed or fixed responses in the way that a more quantitative interview or questionnaire would have done.

In seeking to ascertain whether the 1990 Act had led to any significant changes in mental health services, the study was also disadvantaged by the fact that it began in 1992, after the 1990 changes were first introduced. There was, therefore, no possibility that the research could be a strict 'before and after' study. The study was unable to establish a 'baseline' from which to judge any potential changes. This was alleviated, however, to some extent, by asking interviewees to draw on their experience of mental health services in the county before 1990 to ascertain whether there had been any change. Again, though, this relied on their subjective judgement rather than any more 'objective' measures.

In specific relation to the interviews with mental health service users, two possible shortcoming can be identified. Firstly, interviews were carried out with a limited number of users. This raises a question about how representative the views expressed by users in this study were of those of mental health service users in the area as a whole. With limited time and resource constraints, though, only a small sample of user interviewees was possible. As outlined in Chapters Seven and Eight, the fact that some of the findings from these interviews were consistent with those from other studies suggests that the users interviewed in this were not atypical of mental health service users overall. In any case, it can be argued the principal function of a small qualitative sample is to highlight and identify issues which, if desired, can be validated quantitatively with larger samples.

A second possible criticism of the user interviews was that interviewees were chosen by professionals. There was, therefore, a potential for bias with professionals selecting those likely to be most complimentary about the mental health services provided in the county. In the event, however, the user interviewees were sometimes critical about the mental health services in the county. The decision to recruit users through professionals who were already known to them did, though, have the significant advantage that the study was explained to users by someone they were familiar with, rather than by an unknown researcher.

Strengths of the study

As previously mentioned the broad range of interviewees, including managers, voluntary and user group representatives, professionals and users, was a significant strength of the study in that it has allowed the thesis to draw on a variety of different views, perspectives and experiences of mental health services.

An advantage of the specific data collection method chosen, that of face to face, qualitative, semi-structured interviews, was that it did not pre-determine responses. With substantial flexibility in the interviews, respondents were able to identify the most meaningful or important subjects and issues to them rather than being limited to a set of fixed questions or responses. The semi-structured nature of the interviews also allowed the researcher to explore further important issues raised by respondents. This would not have been possible, for example, within a more structured interview or a postal questionnaire. Overall, the use of in-depth, face to face, semi-structured qualitative interviews allowed greater flexibility, depth and detail in researching the topic.

There were also specific strengths to the inclusion of the user interviews within the study. Firstly, it allowed some of the assertions about service improvements made by managers and professionals to be discussed with those people who actually used the mental health services. In this sense, the user interviews enhanced triangulation within the research and gave the researcher the ability to validate findings from elsewhere in the data.

A further strength of the user interviews was that the sample included people using community services and not just those using in-patient services. As highlighted in Chapter Four, many previous studies have concentrated on users and ex-users of in-patient mental health services. Those purely in contact with community mental health services have been relatively under represented within existing studies. With less reliance being placed on in-patient mental health services and greater emphasis being placed on community provision, this study provides an important example of research which has surveyed the views of community mental health service users.

A final strength of the inclusion of user interviews in the study is that it has shown that despite the reservations of some of the literature on research methods, it is

possible to recruit and interview people with mental health problems for research studies. In this study, mental health service users were seen as having an important contribution to make to our understanding of psychiatric provision. They were seen as participants in the study rather than just the subjects of research as has often been the case in the past.

CHAPTER SIX - MANAGERS' PERSPECTIVES

Introduction

This chapter and those that proceed it will focus on the findings from the interviews with those involved with the psychiatric services in the county used as a case study. This chapter examines the findings from the first 18 interviews that were undertaken between June 1994 and May 1995. These were carried out with representatives from the health and social service purchasing organisations, the two NHS trusts providing the bulk of psychiatric services and the main mental health voluntary organisations in the county. They were all interviewed using the same semi-structured interview guide (Appendix A) and these were individuals who were working at a managerial level within the local psychiatric services. The next chapter focuses on the interviews with eight professionals and 16 mental health service users carried out between June 1995 and May 1996. These individuals either directly provided or received services. Chapter Eight will attempt to draw together the research findings from these two levels of analysis and draw conclusions in relation to the existing literature reviewed earlier in the thesis. In Chapters Six and Seven findings from this research will be discussed in the light of existing studies. The chief aim of the following this chapter and Chapter Seven, though, is to present the findings from this research before the substantive discussion of the relationship between the results of this study and previous research takes place in Chapter Eight.

In looking at the interviews with those from the purchaser, provider and voluntary organisations, this chapter will focus on the three main themes analysed in previous chapters outlining the research and policy background. Firstly, the effects of the implementation of a 'market' of purchasers and providers and the attempts to introduce competition in health care. Secondly, the closure of a large psychiatric hospital and the shift from institutional to community care. And

thirdly, the issue of user participation and involvement in mental health services. Where direct quotes from participants are used in this chapter, anonymity is preserved by only identifying the organisations which people are from i.e. health authority (HA), social services (SS), East Trust (ET), West Trust (WT) or a voluntary sector group (VS).

Firstly, however, the chapter will provide a brief outline of the main characteristics of the county and the nature of its mental health services. The previous chapter noted that it was agreed with participants that the identity and location of the county would not be disclosed. As a result, in the section that follows names of units and places have been changed and only a very general insight into the county will be provided in order to preserve its anonymity. Some description, however, may provide some useful background and context for the reader.

The county and its mental health services

The case study was carried out in a shire county in the south of England with a local population of just over half a million people. The most densely populated areas were the two relatively large towns in the county - Trentham in the East and Riverbank in the West. These towns contained areas of social deprivation and in both towns a significant minority of residents were from minority ethnic groups. There were a series of more affluent smaller towns (such as Sheerwater and Stackbridge) and villages dotted throughout the large rural areas in the county.

Before 1994 there were two District Health Authorities (DHAs) covering the East and West parts of the county. After 1994, in common with many other areas in the country, the two DHAs merged to form a single Health Authority for the county as a whole. Two NHS Trusts - East and West - provided most of the mental health services in the county. Both were Community Trusts providing a

range of services in addition to mental health. These included services for older people and those with learning disabilities. Mental health in-patient facilities based at district general hospital sites were also provided by both Trusts at the Radley Unit in Trentham and at the Buckler Unit in Riverbank. A large Victorian psychiatric hospital, Foxton, run by the East Trust also provided in-patient facilities in the county. There were two other Acute Hospital Trusts in the county, one in the East and one in the West, providing general and acute services.

Eight community mental health teams (CMHTs) for adult psychiatry served the county, with four teams covering the East and four covering the West. Two of these in the East are based in community mental health centres (CMHCs) - one in Sheerwater and the other in Stackbridge. The other six teams either had hospital or office bases. The whole of the county had 92 GP practices and in 1994 only eight of these were fundholders.

The 1990 changes, the market and competition

This first section examines respondents' perspectives on the introduction of the NHS and Community Care Act, the nature of the 'market' in mental health services and the extent to which competition was a feature of relationships between the actors within the psychiatric services of the county. Some of the findings from this section were presented in a paper to the annual conference of the Social Policy Association (Lee, 1995).

In relation to the principal issue of 'mental health and the market' analysis of the data revealed that there were four main themes. These were: the early stages of the implementation of the 1990 changes; developing the purchaser role; GP fundholding and mental health services; and competition and collaboration.

'Jockeying for position': early stages in the implementation of the 1990 changes

The study participants at the managerial level were interviewed between June 1994 and May 1995. Even at this stage, some three to four years after the changes were first introduced, there was a certain amount of caution amongst some of the respondents in assessing the impact of the 1990 Act:

> SS: 'We're still in the very early days, it takes a long while for such radical change to be accepted at gut level and cerebral level by the workers involved.'
>
> HA: 'I think it's very early, actually, and as far as actually impacting on services is concerned I wouldn't have thought there was any.'
>
> WT: 'The purchaser/provider split is still relatively new, it's a learning experience for all of us.'
>
> WT: ' . . . you can sort of say that it's been going now for years in one sense but it was such a cultural change in the system and I guess people didn't have the skills to actually handle that. It's been learning as you go along in a sense.'

The 'purchaser/provider split' was introduced in April 1993 within social services compared to April 1991 in the health service. So the changes were very much in their 'early days' within social services. Within the health service, however, individuals still felt that the changes were new. During the early stages of the implementation of 1990 changes organisations had been adapting to their new roles. 'Jockeying for position' was a phrase used by one of the HA participants in the study. It conveys the way that organisations in the county had been adjusting to change. It gives some idea of the fluidity and uncertainty which most respondents highlighted in the relationships between different agencies since the introduction of the changes. The uncertainty manifested itself both between and within organisations.

In terms of uncertainty between organisations, some respondents felt that there had been a degree of adjustment in terms of how agencies related to each other. There had been a shift from a system where previously the DHAs directly managed those providing services to one where organisations became separate and therefore more autonomous. This transition was not perceived as entirely unproblematic by some respondents, as the following quotes from three interviewees demonstrates:

> HA: 'It's been positioning. It's about organisations growing up. I think the power struggle is reflected in people saying purchasers are not going to tell me what to do, purchasers saying we are not going to buy unless you listen to what we want.'

> HA: 'They (providers) are maturing and I think people are getting over that stuff about lets flex our muscles cause we are now a separate organisation and we'll show you how wonderful we are.'

> ET: 'I think, I genuinely feel that, sometimes our purchasers think that they're also our managers and the two roles become a little bit blurred. They think that they still have the old District Health Authority type of mentality and that they are actually managing our services and they manage us. Which of course isn't the case.'

This initial tension seemed to be more marked between the HA and the East Trust. The following response was given by an interviewee from the West Trust when asked about relationships between the HA and the Trust:

> WT: 'We have an extremely good relationship with our purchasers . . . at the end of the day they obviously contract the services that they provide the specification for but if their specification is unrealistic or any of their data collection is unrealistic we can at least have a sensible dialogue over that.'

One interpretation could be that this manager from the West Trust was giving the researcher a more guarded and 'public' representation of the relationship. On meeting someone unfamiliar and from outside her organisation she may have been keen to portray a positive picture of the relationship between her Trust and the

HA. The following comment from an HA interviewee seemed to confirm, however, a substantive difference between the two Trusts:

> HA: 'We had a difficult year with one of our Trusts in terms of frustration that they believe that we can't define our mental health strategy clearly enough and don't answer questions quickly enough so they can deliver a service.'

The underlying tension between the HA and the East Trust seemed to be largely explained by the particular consequences for the East Trust of the planned closure of the large psychiatric hospital, Foxton. The reconfiguration of services brought about by the closure of Foxton would have the greatest impact on the East Trust because the services at Foxton were operated by them. The review of the closure and reprovision plan by the HA seemed to be, therefore, a source of anxiety and frustration for the managers within the East Trust. The sense of uncertainty and frustration about what services the HA may decide to purchase from the East Trust in the future is illustrated by the following comments:

> ET: ' . . . you've got to remember there's Foxton hospital sitting over there with staff in it and patients in it and it's got to be there for another three years certainly. How do those people feel? What do they know about all this? Where are their jobs going to be? What's their relationship with patients going to be like? How do we know this process is fair? . . . So there are whole issues like that where I think purchasers need to get much smarter about their role in enabling services to be coherently and properly managed. You can't cause a disjuncture like that just because you hold the purse strings. You have to think about the consequences of it and I think that sort of thing can make purchaser/provider relationships very strained indeed.'

> ET: 'I don't know but I think there's going to be excitement around some of the muddle coming out of Foxton, which may cause some bitterness on both sides, which is unfortunate.'

The issue of the Foxton closure seemed, therefore, to bring an added dimension and additional tension to relationships between the purchasers and providers in the East of the county. This is an example of how local circumstances have a bearing

on the nature of centrally formulated and nationally introduced organisational changes. The background context of the closure of the large psychiatric hospital in the county was an important factor in tension between the newly created purchaser and provider organisations. Local mental health services were faced with two significant changes: the introduction of the purchaser/provider split; and the hospital closure. The closure of Foxton is examined further in later sections of this chapter.

As well as the effect on the relationship between organisations the 1990 changes had also had an impact within organisations. Some individuals had had to adapt to new posts and new responsibilities, as described by a social services respondent:

> SS: 'It takes time and the effort and the energy that has to go into any major reorganisation, the problems around major cultural change. Therefore you get, from a planning point of view, a sort of a hiatus, a bit of, almost, a planning blight. People who were familiar in familiar posts aren't there any more, those sorts of changes.'

On a more personal level, some degree of adaptation was needed in adjusting to a different kind of relationship with former colleagues. Those who had previously worked together may now be working within separate organisations and as the following two respondents suggest that could be problematic:

> SS: 'Until just over a year ago we were all close colleagues and certainly our director has said that we need to learn to be different, more different and separate more widely before we can begin to come together again. And to an extent, on a social level, that separating can include quite close friends. It's in the process of evolution at the moment. We are beginning to see ourselves quite sharply as separate sides. I think we've probably got further to go, and some of it will, perhaps, be less than pleasant because obviously our direct services colleagues will be in direct competition with outside agencies and won't necessarily always seen to be what is in the best interests of customers.'

ET: 'Most of the people who work here worked for the same authority until two years ago. So there's a sort of artificiality. Lots of them are social friends, so you've kind of got to bear that in mind to start with. There's something artificial about it.'

So there had been a process of positioning and adaptation both personally and professionally on all sides in the early stages of the implementation of the changes. A particular problem, noted by both purchasers and providers, however, was the development of the purchasing role within mental health services. The next section will explore this issue in more detail.

Developing the purchaser function

With the creation of the purchaser/provider split it was envisaged by the government that health authorities would assume responsibility for assessing the needs of their population and purchase or commission services which best met that need. Both purchasers and providers acknowledged that initially the purchasing function in mental health was relatively weak in the county and specifically problems were identified with the assessment of local needs for mental health services:

HA: ' . . . there is so little information about how you quantify need, how you quantify anything to do with mental health services.'

HA: 'We are struggling, I think, frankly, because we don't get flows of information but I think it is things like community team contacts, admission rates, re-admission rates which we have great difficulty getting hold of.'

WT: 'I think the areas that people are still learning on is using data to identify where the greatest needs are. So that we're not just doing blanket services for example with CPNs across the whole of the West of the county when there are greater needs within Riverbank where there is deprivation and larger groups of ethnic minorities.'

In terms of the actual knowledge and information required by purchasers, two sources were discerned by one HA interviewee. He had been working directly on the development of the Strategic Direction Statement for Mental Health Services in the county and had been trying to establish what services were currently provided and what should be provided in the future. The first source of information he identified was a 'top down' or 'corporate' view. This knowledge was derived from the views of mental health service managers, professionals and voluntary, user and carer groups about where there were unmet needs or service deficiencies. The second type was a 'bottom up' view based on more in-depth information about service use and activity. Whilst he felt that his health authority had a good idea of the 'top down' or 'corporate' view of where the gaps in services were, they did not yet have a detailed picture of the 'bottom up' view.

The manager was optimistic, however, that the Care Programme Approach (CPA) would begin to provide purchasers with this kind of information. Under the CPA regular assessment forms and care plans were to be filled out by professionals about mental health service users. These forms would record both the needs of each individual user and the programme of services, agreed by professionals and users, which would be provided to meet those needs. In the eyes of this particular HA manager, this information, when aggregated, would provide purchasers with a more detailed indication of overall needs and gaps in services in the county. Resource allocation and service provision could then be adjusted accordingly. As an illustration of this he pointed towards how resources were traditionally divided between the smaller, relatively affluent towns and the larger, more deprived towns within the county:

> HA: 'At the moment there is a tendency just to divide the resources up on a capitation basis. If there are eight per cent of the population of the county in Stackbridge they get eight per cent of the mental health resource but we know that places like Stackbridge don't attract loonies (sic). Loonies get attracted to places like Trentham and Riverbank because that's where the cheap housing is, that's where the pubs are, where they'll get a

> beer and where they go largely unnoticed and sort of hang around the shopping centre and things like that. Where as in Stackbridge they'll get spotted and life can be made pretty uncomfortable for them until they move on. So we do need that information to ensure that whatever resource we've got for health, that it's actually focused in the right place . . . we need to understand, if there are very, very few, comparatively few people with long term psychotic health problems in Stackbridge, we know that we don't need to have as strong a CMHT there, pro rata to what we are putting into Riverbank.'

There was also an equivalent process to CPA within social services called Care Management. Respondents within social services were also hopeful that this would provide them with more information on needs:

> SS: 'From social services point of view one of the things we are extremely bad at is actually plotting need. We've been very bad at that so we've been very reliant on the data from health. What we are beginning to do is actually use our Care Management process and part of that we've got is a service deficiency reporting mechanism. I mean that's still very crude but it's beginning to highlight some areas. So it's stitching those together.'

Explanations for the purchasers' lack of existing information about the mental health needs of the area were provided by some interviewees. One explanation was that there was a lack of personnel with the appropriate knowledge and experience of mental health services:

> HA: 'I think all the management effort in the first two or three years of the purchaser/provider split was about creating Trusts, was about providers, making them stand alone and not being part of the DHA. What we found was, and what we found nationally, is that the DHAs as they were configured three or four years ago, which was usually around a population of about a quarter of a million, the infrastructure at the centre of the DHA, the people who emerged as purchasers, the infrastructure was insufficient to actually do the job properly. What actually emerged, was three or four public health professionals and three or four contracting managers who were charged with actually driving the whole purchasing agenda.'

What knowledge and experience of mental health services that did exist on the purchaser side was also spread across the two DHAs that existed in the county in the initial stages of the implementation of the 1990 changes. The merger of the two DHAs into a single commissioning agency was, therefore, seen as a significant development. It allowed what knowledge there was around mental health to be brought together into the one organisation. Other respondents, including those in the Trusts, also pointed towards the appointment of an individual from outside the area with experience in mental health at a senior level in another health authority as a significant aid to the commissioning agency. His appointment and the experience that he brought appeared to boost the confidence of those in the Trusts that the health authority knew what the particular problems and issues were in mental health.

The lack of personnel on the purchaser side with in-depth knowledge and experience of mental health services was also attributed by another interviewee to the fact that when the purchaser/provider split was created, most of those who had previously been most closely involved with managing psychiatric services went to the provider side to work at the Trusts:

> SS: 'the problems within health were that it meant people who actually had a knowledge about mental health were distanced from the people who were actually buying the services. Going back five years, when those same Health Authorities wanted to know something up at the head office they actually had direct access to the information. Now you're actually talking about a company operating, selling a service, very few people actually on the commissioning side understanding the issues.'

As well as HAs taking on a purchasing role in the wake of the 1990 Act, under the fundholding scheme, GPs were also given the ability to directly purchase some of the mental health services used by the patients on their practice lists. The limitation of time meant that no GP fundholders were interviewed for the study. The managerial interviewees, however, were asked what they thought had been

the impact of fundholding on mental health services and therefore the issue is briefly discussed below.

GP fundholding and mental health services

The impact of GP fundholding both specifically on mental health services and on health services in general in the county was felt not to be that significant by those interviewed. This was largely due to the fact that, compared with other areas, the county had relatively low numbers of GP fundholders. Despite this, though, where there were GP fundholders in the county there was some evidence that they had begun to exert an influence and challenge the Trusts in some areas of mental health service provision.

GP fundholders in Stackbridge had begun to start purchasing their outpatient mental health services from providers in neighbouring counties. They felt that the service at the Radley Unit, on the district general hospital site, was of poor quality and did not respond quickly enough to referrals. It was also felt that the unit was too far away for their patients to travel to. The GPFHs had decided to contract with other providers outside of the county because they believed they could get a quicker and better quality service that was more geographically accessible for their patients. A fundholding practice in Trentham had made savings elsewhere in their budget and had wanted to buy community psychiatric nurse time so that people would be treated in the surgery. Another fundholder wanted to hand all of its budget for the community mental health team over to the East Trust in return for dedicated psychology sessions within the practice. The Trust, however, in both of the two latter cases was not responding to these requests. The Trust felt that providing services within the practice would divert already spartan resources away from the community mental health teams. They also felt that resources would be directed away from the severely mentally ill and towards those with less severe problems who are the main client group within primary care.

In these particular circumstances the fundholders took their money elsewhere and purchased services from providers outside of the county. This was of some concern to the health authority. The HA supported the fundholders in their attempts to shift services towards primary care which they felt would be less stigmatising and more accessible than services provided at specialist psychiatric units. The HA, however, also shared the concern with the Trust about the diversion of limited resources away from people with severe and enduring mental health problems. While the numbers of fundholders remained low in the county their ability to affect detrimentally the overall mental health service would not be significant. Those in the health authority, though, felt that if the number of fundholders in the county increased the situation would need to be monitored to establish whether the Trust's fears were justified. Despite the need to monitor any adverse effect of fundholding on mental health services the scheme was viewed positively by most of the purchasers. The ability of fundholders to challenge or 'prod' parts of the system at a micro level was seen as important by managers in the HA. The position of those within the HA was, then, ambivalent. On the one hand they supported attempts by GPFHs to try to make changes in service provision. They also thought, however, that if mental health professionals were drawn into primary care there was a danger that they would work more with people with less severe mental health problems. Milder mental health problems represent a larger proportion of the workload for primary care than people with severe and enduring mental problems. Mental health professionals from secondary care who worked more closely with primary care may thus be diverted away from those with more severe problems who were seen as a priority by central government policy. The HA viewed its role within the disputes between GPFHs and the Trusts as one of 'peacemaker'. Yet with the GPFHs having decided to purchase services from elsewhere the HA appeared to have been unsuccessful in achieving a compromise between the two parties. In the long term it was not clear what position the HA would adopt.

There was some evidence then that GP fundholders in the county were attempting to use the mechanism of the internal market to try to put pressure on providers to change patterns of service provision. The small numbers of fundholders, however, meant that the Trust was able to resist such change. The loss of the 'business' of a few GP fundholders did not appear to threaten the financial viability of the providers. The next section moves on to look at the extent to which there was a 'market' in mental health services more generally. The chapter will explore whether the potential levers of competition were being used by the HA purchasers in their relationships with mental health service providers.

Competition and collaboration

The relationships between the different agencies in the county under study were not easily categorised as either competitive or collaborative. As has been suggested by Rea (1995), it is perhaps more useful to consider that concepts like competition and collaboration co-exist in the relationships between individuals and organisations.

Competition had become a feature of mental health services but these seemed to be in specific areas of provision. For example, the purchasers had set up a competitive tendering process for the reprovision of the long term care of elderly mentally ill people currently provided at Foxton Hospital which was scheduled to close. The two NHS provider Trusts, social services providers and private agencies were all bidding in this process. This was a clear example of organisations competing against each other. When participants were asked if competition was a feature within mental health this tendering process was often used as an example to illustrate that it was.

It was also argued that there was a 'market' in the specialist area of secure provision. The East NHS Trust ran facilities with locked, secure wards which often received extra contractual referrals (ECRs) from other districts. As the name suggests, ECRs are referrals which were not agreed under the yearly contractual agreements between purchasers and providers in each district. If a Trust receives an ECR it will also acquire extra income. Those in the Trust felt that the shortage of secure places nationally meant that they often received inquiries from other areas. Thus if there were secure beds available, providers would have few problems in ensuring that they were occupied. The competition for secure provision can be defined as taking place in the context of a national rather than a local 'market' the conditions for which were established by a shortage of places across the country.

The above examples seemed to be the only areas of mental health service provision in the county, pointed to by participants, where competition did exist and other providers were willing or able to bid for the contracts that existing providers had with purchasers. It was envisaged that the bulk of general hospital and community based mental health services in the county would continue to be run by the those who currently provided it - predominantly the East and West NHS Trusts. This would seem to suggest that while there may be some areas of competition where the kind of organisation providing services may change, as Bartlett and Harrison (1993) found in their case study of health care in general, overall patterns of service delivery had remained largely unaltered since the 1990 Act was introduced.

The overall impression was that competition within mental health would only happen at the margins:

> ET: 'If you look at which model each organisation can offer and if they're willing to be frank about that, there's a natural place for everyone working

in harmony. Okay there may be, between organisations, a bit of grey area but it's not that significant.'

ET: '. . . you had that range of services in place. There wasn't suddenly going to be a magical new market available full of resources that could be offered as an alternative. I mean slowly you're getting some creeping at the edges but in services like mental health most private sector providers only want to come in certain bits. They are not very interested in other parts of the service.'

It was felt that mental health services, especially those for people with long term problems who may require quite extensive support over a long period of time, offered few incentives for new providers who may be primarily interested in profit.

It was further suggested that there was an inherent tension in the co-existence of both competition and collaboration within mental health services:

ET: 'I think for services like mental health, which by definition need multi-disciplinary and multi-agency input and need that on a very co-operative and collaborative basis, if you set people up against each other, in competition, it is actually a bit naive then to expect them all to be "budsy wudsy" on Monday morning and suddenly friends and neighbours again. So I think you have to be quite careful about how you operate the market in mental health.'

ET: 'To be fair to the dear old purchasers I think they've got double messages coming from the government. Having been told to be more robust in terms of managing the market and on the other hand if you read Health of the Nation and all these other things it's telling them that they should be making sure that co-operative working exists. The two don't logically go hand in hand.'

Whilst one of the principles underpinning the changes introduced by the NHS and Community Care Act was that greater efficiency and effectiveness would result from agencies competing for contracts, many of the reports and inquiries into mental health services have also stressed the importance of organisations working together to improve standards of care. Two major examples are the report

resulting from the inquiry into the case of Christopher Clunis, who killed Jonathan Zito outside a tube station in London (Ritchie, 1994), and the review of mental health services for adults in 12 districts in England and Wales by the Audit Commission (Audit Commission, 1994). Both these reports have argued that a more collaborative environment with better communication and joint working between all local agencies and individuals involved with mental health care is the key to improving the effectiveness of services.

Both purchasers and providers in the county under study viewed the tension between the introduction of competition into the health and social care sectors and the need for greater collaboration between local mental health agencies as a dilemma that needed to be addressed. There was a clear concern that seeing health and social services in competitive terms would be particularly damaging to a specialist area of provision like mental health because it may lead to fragmentation rather creating a more 'seamless network of services' with individuals from different groups working together. The following comments illustrate a shift towards emphasising collaboration:

> HA: 'It just feels as if there is an awful lot to do to keep the relationships going but I think people are prepared to move back into "let's talk and work together".'
>
> ET: 'I think because we've had a history of healthy alliances and our new Code of Practice that we're bringing out as well with the voluntary organisations, we've been able to hold together the alliances and I think this Trust making statements that it's more interested in healthy alliances than explicit competition may have helped that in lots of ways. But I have a sensation that people are beginning to turn back towards the understanding that being highly competitive in this market is pretty detrimental.'
>
> ET: 'I think all the kind of open minded professionalism that was beginning to grow has reacted quite badly to the threats the reform has posed. So everybody does the natural thing and goes back into their camps and kind of shuts the door and comes out when it's a bit safer. I think it's only now, perhaps two or three years on, that people are

beginning to open their doors again and are saying "well, perhaps, I can talk to you and it doesn't mean you're going to nick my contract next week".'

A Code of Good Practice was developed by the East Trust with local voluntary sector organisations. It attempted to encourage more effective joint working between the two by setting out guidelines on areas such as care planning, referrals, complaints and multi-agency working. Closer links were felt to be particularly important for mental health because of the way services worked at an operational level. For example, in the community mental health centres in the county individuals from health and voluntary organisations, as well as those from social services, were all physically based together and worked alongside each other on a day to day basis.

It could be argued that since they had most to lose, providers would naturally be opposed to the concept of increased competition. This was something one manager seemed to be aware of but she contended that her opposition to a more 'market' orientated approach within mental health was not purely motivated by the need to retain 'business' and, therefore, funding:

ET: 'I think there is a tendency to think that when providers express those views they are being defensive about their place in the market and that's all that's heard. The care issues tend not to get heard. There's actually a reason why you're saying this. It's not about trying to put your arm round the service and say they must never change.'

In any case, purchasers were also concerned about the potentially damaging effects of a 'market' within mental health services:

HA: 'There is a fragmentation of the services with people being mainly concerned about the little bit that they are running rather than integrated care to a patient or a group of patients.'

SS: 'My personal feeling is that in specialist areas of provision there's been a real kind of downside to the purchaser/provider split because I

> think it has led to a fragmentation or perhaps the beginning of a fragmentation of any notion of a total service. I think itís a real teaser, in the sense of a new conundrum of given these arrangements how you stitch back together a comprehensive service and I think that currently appears to be a fairly kind of major challenge.'

Most interviewees seemed to identify a tension between a 'market' of separate purchasers and providers and the need to collaborate to create a comprehensive and integrated system of mental health services.

The introduction of mechanisms designed to promote a more 'market' orientated approach had an effect on the relationships between individuals and organisations involved at the managerial level of mental health services in the county. The changes did not appear, however, to be have had an extensive impact in terms of shifting patterns of mental health service provision. Respondents were asked directly if they felt that the changes had had a direct impact on the services and care that users actually received. There seemed to be a general feeling amongst those interviewed that the changes would not yet have had an effect on mental health services users. This issue will be explored again in the next chapter which focuses on the interviews with users and professionals.

The scaling down of provision and eventual closure of Foxton Hospital, the large Victorian asylum in the county, though, was seen as significant by those interviewed. The next section of this chapter outlines what the managerial respondents saw as the consequences of the closure of Foxton.

'Past its sell by date': the closure of Foxton hospital

This section of the chapter will look at three issues. Firstly the role of purchaser/provider split in the closure of Foxton hospital will be examined. Secondly, the issue of the reprovision of services to replace those currently provided at Foxton is considered. Finally, the consultation process initiated by the

purchasers with all those with an interest in mental health services in the county will be discussed.

Role of purchaser/provider split in the closure

The provision of mental health services had been reducing at Foxton Hospital over a number of years in line with the overall national policy of shifting mental health services away from the old long stay Victorian asylum towards more localised, community services. The managerial interviewees in the study were unanimous in the view that Foxton no longer constituted an appropriate place for people to be treated in and should therefore now be closed completely. There was acknowledgement that the hospital and the staff who had worked in it had provided good care in the past for the patients admitted to it. Now, however, all seemed to agree that it was no longer a satisfactory environment for people with mental health problems. One manager in the East provider Trust summed up the attitude all of the interviewees when he said; 'the building is 140 years old and past its sell by date'. The only notable disadvantage of the closure of Foxton highlighted by any of the managerial respondents was raised by this same manager. This related to the fact that any new unit would not be based in large grounds. He felt that many people found the grounds relaxing, away from the pressures and noise of traffic and 'the hustle and bustle' of everyday life. Despite the possible benefits that the large grounds of Foxton may bring, however, access to it was difficult for both users and their relatives because it was located out in the countryside a considerable distance from the population centres in the county. Thus the same manager also argued that:

> ET: 'the reality is that very few of us live in huge great big parks like that. We all live in busy streets and you know in a busy, hustle and bustle sort of rat race of society.'

It was argued by one respondent that the process of finally closing Foxton had been given a greater impetus by the introduction of the purchaser/provider split. The creation of a commissioning or purchasing organisation separate from those who directly managed and provided services had allowed it to 'step back' and review the services currently available. A consequence of this had been the decision that the process of closing Foxton should be encouraged and speeded up:

> HA: 'It's given us the driving force to drive things like the closure of institutions, which I don't think any of us like, they suck up a lot of money, and try and reprovide services locally. So, that I think has been the main advantage of the split.'

Another respondent, by contrast, felt that the closure process was ongoing before the 1990 Act and that Foxton's eventual closure was inevitable:

> ET: 'I don't believe that (the 1990 Act) has made a difference. That was going to happen anyway.'

Most other respondents identified the introduction of the purchaser/provider split as an opportunity to 'step back' and assess the state of current provision. They did not, however, specifically identify the subsequent drive to close Foxton as a significant part of that. In Chapter Four it was noted that the NHS and Community Act had been predicted as offering an opportunity for change and reassessment (Read and Wallcraft, 1992). In the case study county the focus of reassessment within mental health services appeared to be the services that would replace those at Foxton, which is the focus of the next section of this chapter. The closure of Foxton itself seemed to be accepted as inevitable and therefore most respondents did not identify the 1990 changes as significant in that process.

One respondent in the East Trust , however, argued that the purchaser/provider split had slowed down the Foxton closure. The split had meant there had been 'a review of the services by someone outside of the services who are actually

providing it'. This was, though, another review of the closure plan by people 'who didn't really have a clear understanding of mental health'. Therefore, more time was taken up by them learning the issues and reviewing the options for reprovision. This manager felt that this had all been done before.

The final closure of the institution, all sides agreed, would, though, represent a real opportunity to develop more local and comprehensive community based services. This would be possible with the financial resources that the closure of Foxton would release. The next section of the chapter moves on to examine the issues and debates around the nature of the services to be reprovided with the funds that the closure of Foxton would make available.

Reprovision of services

The purchasers in the county were clear that they wanted to reprovide more community based alternatives to the services available at Foxton and also use the funds released to enhance the existing community provision. This was perceived to be made problematic, however, by the lack of a clear vision from central government about the future shape of mental health services. The vagueness of the term 'community care' has been identified by Goodwin (1990) and Chapman *et al.* (1991). One HA purchaser argued that the only real meaning of 'community care' for mental health was a service without the long stay Victorian institutions. Another HA interviewee argued that what they wanted from the Department of Health was a compendium of good practice to act as a benchmark against which they could measure their own services. This would allow them to identify where the gaps in their service were and what services at the very least should be in place to ensure that they had a comprehensive local mental health service. The problem was not that as purchasers they were getting a lack of central directives. One HA manager said that the number of directives had recently been reduced but that they still struggled with the reduced number. The purchasers in the county were just

not getting the kind of directives and information from the centre that they wanted. In place of this, at the time that they were interviewed, the purchasers said that they were getting a number of directives about the need to concentrate on the issue of safety after a few highly publicised incidents involving users of mental health services, notably the killing of Jonathan Zito by Christopher Clunis referred to earlier:

> HA: 'I find it a dilemma because I think when you get someone like Jonathan Zito stabbed on Finsbury Park tube station, I understand why politicians have got to react but it is a one off and I think there should be a recognition that you will always have risks with people who are mentally ill and if you are not going to run a "let's bang these people away in institutions" service, that's what we've moved away from, government has a responsibility to let society recognise that it has risk, particularly if it is only going to spend a limited amount of money on health care.'

Without the kind of central guidance that was required, the Strategic Direction Statement for Mental Health produced in the county looked to principles set out by the national mental health charity MIND in its 1983 document 'Common Concern' (MIND, 1983) to underpin the development of services. The experience of other areas also proved important. Examples of good practice in other parts of the UK, as they tried to create alternatives to traditional hospital based mental health services, were seen as important guides.

As highlighted earlier, it seemed that the purchasers dilemma about what services should replace those at Foxton was a cause of tension between them and the providers. Respondents from both sides mentioned that a particular issue of contention between the two had been how many beds should be available in the new facilities that would be developed as the final wards were closed at Foxton. The purchasers as a whole were keen to reduce the reliance on in-patient facilities and put more investment into community support services. Whilst this objective was shared by the providers they were concerned that the number of beds should not be reduced too dramatically. It was their view that, even with improved

community services that allowed increasing numbers of people with mental health problems to be supported in their own homes, there would still be a considerable number that would need to be admitted to inpatient units for short periods of time. The provision at Foxton which was the subject of debate between the purchasers and providers concerned acute, intensive, rehabilitation and elderly mentally ill beds. One Foxton ward of 25 acute beds was provided for residents from Stackbridge and Sheerwater. Two secure, locked wards with a total of 32 beds provided intensive care for the county as a whole, as well as for parts of a neighbouring county. The rehabilitation facilities provided longer term care for a range of people including those long stay patients who had been residents at Foxton for many years. A variety of wards and hostels provided a total of 162 rehabilitation places within Foxton. A total of 261 beds were provided for elderly people who were classified as having functional or organic mental illness such as dementia.

By the end of the case study period in May 1996 it was not clear if the issue had been resolved and the exact numbers of beds had been agreed. What was clear, however, was that the consultation process around the reprovision plans had thrown up concerns about the actual location of the replacement in-patient facilities. The consultation process took place between December 1993 and March 1994, just before the tape-recorded interviews were carried out with the purchaser and provider managers. In its Reprovision Plan the Health Authority had suggested that the in-patient facilities that remained at Foxton would largely be transferred to new wards and units on the site of the existing district general hospital site in Trentham at the Radley Unit. Consultation on the Reprovision Plan involving the community health council in the East of the county revealed reservations amongst users and mental health voluntary groups about this plan. They argued that the site was already crowded and the existing facilities there were 'very claustrophobic' and 'lacking in space and privacy'. A consumer audit of mental health users carried out on behalf of the health authority also reported

that negative opinions were expressed by those who had been admitted to the Radley Unit. Towards the end of the study period the reprovision plans had been revised and it was proposed that three smaller purpose built units should be constructed in three separate locations in the county rather than all the facilities been concentrated on the Radley Unit site. One of the last provider managers to be interviewed, however, had argued that more extensive costings of the option of three smaller units had meant that it was not financially viable. At that stage he thought that the original plan of basing reprovided services at the Radley Unit would be the most likely outcome. At the end of the case study period the final closure of Foxton had not taken place and it remained uncertain as to which option would finally be chosen.

Having highlighted the issue of the relocation of services provided at Foxton which arose during the consultation process around the reprovision plan, the next section looks at the consultation process more generally. This is an important issue within the thesis because it is an example of an attempt to consult with users about the planning and provision of mental health services in the county. It is, therefore, related to the central theme of user involvement within this study.

The consultation process

The Hospital Closure and Reprovision Plan (HCP) for Foxton was produced by the purchasers around the same time as the overall Strategic Direction Statement for Mental Health Services (SDS) in the county. The two documents were seen by the Health Authority as complementary. Well over a hundred different organisations with an interest in mental health services both within and outside the county were sent either full copies or summaries of the HCP and the SDS depending on their level of involvement in mental health issues. In a letter accompanying the documents they were invited to return written comments to the Health Authority. The researcher was given copies of these responses by an

interviewee in the Health Authority. Both East and West community health councils (CHCs) organised a number of events to obtain public and user views on the HCP. They held both public meetings and 'consultation days' where groups or individuals were invited to book hour long 'slots' to discuss the Foxton closure with representatives from the CHCs. The East CHC also organised a one day conference about the closure attended by representatives from both health and social service providers, the voluntary sector organisations and the CHC. The researcher also attended the conference at the invitation of one of the HA managers during a preliminary meeting about the study.

The consultation was an extensive process and it is beyond the scope of this chapter to cover all the issues which arose during it. There seemed to be three main issues, however, that came out of the consultation process. This is based on the interviews undertaken with the managerial respondents, examination of the written responses to the Health Authority and the researcher's attendance at the one day conference about the closure of Foxton.

The first issue, which was highlighted earlier, emerged mainly from the consultation undertaken by the CHCs with service users and concerned the appropriateness of reproviding the services from Foxton at the Radley Unit on the district general hospital site.

A second issue which was evident both in the written comments to the health authority and at the one day conference organised by the East CHC was around the elderly mentally ill people who would be discharged from Foxton. There was a concern about whether there would be an adequate level of acute beds and provision for elderly mentally ill people in the NHS and the independent sector once Foxton had closed. There was also the fear from voluntary, user and carer groups that the continuing care for older people suffering from mental health

problems would move from being free within the NHS towards a means tested system in the independent sector.

A third major issue which could be discerned from the consultation process was the provision of day care. Again there was concern about whether the level of provision would be adequate in the future. A voluntary group, which was providing a large component of the day care in the county, expressed particular concern. They felt that a sufficient level of day care provision was vital to prevent people, particularly those with severe mental health problems, from becoming isolated in the community. The group noted that there were no specific costings in the reprovision plans for day care and felt that this was a serious omission.

Despite reservations such as those outlined above, overall the Health Authority was praised by the CHCs, voluntary and user groups both for the documents it consulted on and the way it consulted on them. They seemed happy that they were being adequately consulted on and involved in the closure of Foxton. The case study period for this research ended in May 1996 before Foxton actually closed. As a result it is beyond the scope of this study to discern whether the concerns raised by the CHCs, voluntary and user groups have been addressed by the purchasers. It is also not possible to say whether their fears about the lack of provision in areas such as services for the elderly mentally ill or day care have proved well founded.

Having briefly looked at the consultation and involvement of users and their representatives in the closure of Foxton, the chapter now moves on to examine the wider issue of user involvement and participation in mental health services at a strategic level in the county.

User involvement

This section on user involvement looks at the managerial interviewees' responses and opinions on three main issues. The first is their own and general attitudes to the involvement of mental health service users. The second issue is the extent to which there are structures and processes in place within the county to involve mental health service users in the purchasing, commissioning and planning of services at a strategic level. The final section will examine the involvement of users in the operation of specific mental health units and centres within the county.

Attitudes to the involvement of mental health service users

All respondents agreed that involving users in the planning of mental health services was problematic, although this did not mean that it was not worthwhile and should not be attempted. Purchasers, providers and representatives from voluntary and user groups all felt that it was vital that users should be encouraged to express their views about services. Below, three respondents explain why they feel that user involvement is important:

> SS: 'What I am doing is, I am state funded to provide a service for customers and if nobody is looking at what I am doing and challenging decisions I make, or my staff make, then customers may not get the best service that is possible within what we've got to offer.'
>
> HA: 'Personally I feel and I 've managed to convince people that that's money well spent because it will continually challenge the services and it needs to be challenged. They do need to be prodded to say well why are you doing it that way, isn't there a better way, I don't want this, I want that. So I think that's important.'
>
> WT: 'I think it's very important because it's so easy in any area of the health service not just in mental health to not see things from the patient or the client's point of view. What we see as acceptable or what we feel is sufficient information may not be saying anything to a patient. We may

> have leaflets that are worded in language which isn't understandable. We are continually trying to improve the information we give people but we've got to have feed back to find out if what we're doing is satisfying their requirements.'

There seemed to be an overall commitment from those interviewed to involving users in the planning of services and to gaining their views. Some felt, however, that it was particularly difficult to involve people in the acute stages of their problems, when they are most distressed or disturbed:

> ET: 'I think that the nature of mental illness being what it is when a person is acutely and severely ill, by definition it is more difficult for them to participate. I think when they recover and perhaps through the process of recovery both they and their carers have a voice and a view and we encourage them to express that.'
>
> WT: 'I think and this is information I've gleaned from people with greater clinical knowledge than myself, that user involvement during the stage of people's acute illness is not going to give valid results. So we tend to, we're only just moving into areas of user involvement, we are looking at concentrating on having a dialogue with people who are through the acute stage of their illness and are perhaps going for some kind of therapy or day care facilities when they are feeling a little better but have been in-patients and so can look back and hopefully give us some thoughts about times when they were in-patients.'

The emphasis on 'validity' and involving people when they are not at their most distressed could be construed as marginalising people and their experiences. Such comments do reflect, however, the reality that there are practical difficulties associated with involving people who may be severely distressed. The last chapter which discussed methodological issues noted that this research had not sought to interview users at the very early stages of their involvement and contact with mental health services. It would perhaps be hypocritical, in the light of this, to be over critical of respondents who had articulated similar views about the practicalities of consulting and involving people at their most distressed. Such comments by respondents did not, in any case, appear to represent a wholesale rejection of involving users who had been through periods of acute distress just

that the process may be easier once people were over the extreme or severe stages of that distress.

Some comparison was made by respondents between the involvement of mental health service users and the involvement of users in the planning of and decisions about other services. One respondent from the health authority felt it was difficult to get user involvement in any service. Yet in mental health he felt that there may be more incentive for user involvement since their contact with services would tend to be over a longer time period than with general acute medical treatment:

> HA: '. . . in the case of mental health because it tends to be a long term problem, so that people are very deeply affected by it and may be more motivated to actually try and articulate what, how things should be different. Whereas with acute services it's all over and done with before you've got round to thinking about it.'

Despite this a provider felt that there was degree of reluctance and reticence amongst those using mental health services that was not apparent from users of services aimed at people with physical disabilities who he argued tended to be 'very good lobbyists'. Within mental health services he felt there often needed to be a greater level of encouragement, by managers and professionals themselves, to get users involved. Some respondents felt, however, that this had to be managed carefully so that staff did not dominate the process:

> ET: 'We have to be careful. We have to sort of stimulate our clients, if you like, our staff helping to stimulate our clients to set up groups and to give them support and facilitate those things. We have to be careful that they're not staff-led groups because otherwise that just defeats the object of the group in the first place because what will happen is that the staff will talk in the groups and patients won't.'
>
> ET: 'I think it just needs continuous, concerted energy to keep it moving, particularly if you're going to really make it owned and developed by the users. I mean okay you can set up structures which are managed by the Trust where you have your users come along and they are herded in and

herded out but if you actually want it to be vibrant and by the users, for the users, it's going to take a long time.'

Other respondents raised concerns about gaining views that were representative of all those using mental health services rather than a vocal minority:

SS: '. . . the user groups are nearly always very small. So the real difficulty remains to get democratically acceptable representatives of user views who are prepared to engage with purchasers and providers in health and social services, housing, voluntary agencies.'

ET: 'I think again it's one of those things that will take some time to establish properly and I'm a bit wary of tokenism in user groups and user participation. I think you've almost got to get the atmosphere and the philosophy right before you can even start thinking about it seriously.'

SS: 'I know that there are people amongst the users who can speak effectively, they can voice their own opinions, it's harder to say that they can realistically and democratically represent the views of other users because so many of the users would neither want nor be able to part of that process.'

Against the background of a general reluctance of mental health service users to voice their views about services that some respondents had identified, they felt it was dangerous to assume that those who did speak were doing so on behalf of all users. Some respondents also felt that user involvement had to be carefully handled because of the impact it might have on staff:

ET: 'I want to improve the services to our clients. I want to take on views but by the same token I have to ensure that, as best as I can, that's not done negatively or destructively, or that can cause more harm than good. So I'm very keen to get people involved in this but it's got to be, you know, done constructively and positively.'

HA: ' . . . it seems to me there are some messages about training professionals who should not be threatened by that sort of response and should enable them to sort the kind of jibes you might get from someone who has a personality disorder, who is wreaking havoc and stirring the world up as opposed to those very genuine descriptions of what people's experience of the service is. I wonder if independent focus groups feeding

through or feeding back to health, social services and providers are not a better a way than overall studies which, when it is written on paper, tend to cause alienation.'

HA: 'I think it's very important that staff and managers are part of the process. I think it doesn't matter what report lands on your desk, how you've done it, if that is critical of what you've been doing or it is completely off the wall compared with your own thinking then it's going to cause tensions.'

In referring to the problems of reports and studies which starkly present criticisms to staff on paper, these respondents were talking about a consumer audit on mental health services that had been conducted on behalf of the HA by an outside research agency. This was highlighted earlier in the chapter on the section examining the closure of Foxton. Respondents felt that staff working in the East Trust working within the Radley Unit had been upset at the comments made by users. There did not seem to be any indication from the managerial interviewees that the comments made by users were unjustified. Interviewees were concerned, however, that if criticism was not presented constructively to staff then it would be difficult to engage staff and act on those criticisms. An HA purchaser felt that negative messages like those from the consumer audit must be difficult for professionals who may 'curl up and think God and here am I doing my best and busting a gut.' It seemed, therefore, that some managerial interviewees felt that, in future, the situation would need to be handled more carefully so that staff were not antagonised and became too defensive. In one of the quotes above, one HA interviewee suggested that it may be more constructive for such issues to be worked through in groups involving contact between users and professionals rather than criticism appearing on paper where it tended to cause alienation. Equally though it could be argued that the anonymity of users' views presented as a group may allow issues to be raised, which users may not feel able to highlight personally with professionals. The power imbalance between users and professionals could militate against users openly expressing their views.

Overall respondents seemed clear that it was right to involve users in decisions about mental health services. The model of involvement within the managerial interviewees' comments seemed, however, to be largely consultative. Their remarks appeared to be centred on gaining users' views of the mental health services they received. There seemed to be little indication of how more extensive involvement in terms of users becoming part of decision making and planning around mental health services would or could be achieved. The implication was more that managers should be aware of and take notice of user views but the possibility of users taking a more active part in service planning and development seemed limited. So beyond being questioned about a general commitment to user participation in principle, those interviewed were also asked about the kind of specific initiatives, structures and processes that had been set up in the county to facilitate and try to achieve greater user involvement in the local decision making process. The main points to emerge from their responses are outlined below.

Local user involvement at the strategic level

Despite an overall commitment to involving mental health service users in the planning process, respondents were candid about the fact the county still had a lot to achieve. They acknowledged that compared with other counties and areas the level of user of involvement was still quite low and that the county was just starting out on the process of trying to encourage more participation from users of its psychiatric services. A key problem was that historically there had been a lack of strong mental health voluntary groups who had also taken on a campaigning role which could encourage greater user involvement:

> SS: 'I think in [this county], in comparison with places like Nottingham or somewhere, the chair of their joint planning group is a user of mental health services, [this county] has got a million miles to go because I think that stigmatising effect is still around. Also I think in [this county] there isn't an alliance of user groups. So certainly in terms of when we have been talking this year to local groups in the west of the county there's been

very much a matter of making contact with a number of very small groups and it's got to be seen as a disadvantage to those groups that they would have a more powerful voice if they spoke together.'

There had been a lack of local level voluntary groups who had been able to stimulate user involvement and also linkages between user groups. One purchasing manager within social services who had moved from another area which had a strong local MIND group had found the lack of user involvement within the case study county particularly noticeable:

SS: 'I think in general in planning terms and in priority terms it's an area where the officers of the department often have to be the service champions rather than looking to lively consumer, customer type groups.'

A representative of the largest mental health voluntary group in the county was interviewed. This organisation provides most of the day care provision in the county and was mentioned earlier in this chapter in the section on the Foxton closure. The organisation had spoken out in the consultation on the Foxton closure plans about the issue of day care. The main focus of the group and its component projects through the county, however, was on the provision of services to people with mental health problems. It was seeking to concentrate on this role rather than acting as an advocacy or pressure group in the planning process on behalf of mental health service users. The services it provided were supported mainly by grant income from health and social services which was awarded annually. The organisation was hoping to move towards a contractual relationship with the Health Authority. This would preferably be based on a rolling contract which it was hoped would mean greater financial security for the organisation and therefore its services. The clear priority was developing its role as a provider rather than an advocacy organisation.

Importance was attached to this distinction between voluntary agencies acting as provider or advocacy groups by some purchasers in the health authority.

Speaking about the role of voluntary agencies in representing users' views one argued:

> HA: '. . . they have got to decide what business they are in 'cause I'm not in the business of purchasing from someone who is going to act as a pressure group and tell me what a lousy purchaser I am every time I meet them, there is no pleasure in that really.'

In the absence of an existing mental health voluntary group in the county that was willing to take on the advocacy role, the health authority was putting money into setting up an independent county wide advocacy service. The initial focus of the service had been the closure and scaling down of Foxton and providing advocacy for individual users who were being resettled elsewhere. This, along with the user representative on the working group involved in the Foxton closure, were highlighted by respondents from health, social services and the voluntary sector as examples of where users and their views were being actively involved in mental health services in the county. It was hoped that the service would, in time, widen its remit to provide more extensive advocacy for users within units across the county.

Respondents also talked about attempts to set up a network of organisations who would represent the views of service users in general in the county, not just those using mental health services. This network would feed into the joint planning mechanism between health and social services purchasers. Setting this up had proved problematic. The representative organisations involved had not been satisfied with the structure put forward by the purchasers and subsequent negotiations had not agreed a revised structure. A manager in social services commented that:

> SS: 'So far we've had a conference, we've had consultation days, so far we haven't got agreement with these umbrella organisations and so it's been down to the chair, the respective chairs of the joint planning teams and in this case the mental health joint planning team to actively ensure that they

> have some means of consulting and it's extremely difficult to get at that and to make sure that that is effective. All I think I can say at the moment that we seem to have been working very hard to get it and I think at the moment we haven't got it going as well as we should.'

Even if a more formalised structure is eventually agreed, though, it seems that the joint planning process will be informed by those representing users rather than users themselves having a direct input. Aside from the Foxton closure, therefore, the extent to which mental health users were directly involved in the purchasing and planning of services seemed limited. There were, however, examples of more direct user involvement in the running of some of the mental health units in the county. This is explored below.

User involvement at the facility level

The managerial respondents pointed towards the community mental health centres (CMHCs) in Sheerwater and Stackbridge as examples of where user involvement was taking place within mental health services in the county. Both centres had user groups which met regularly and user representatives on their management committees. The chair of the user group at Sheerwater CMHC was interviewed as part of the study and at his and the group's invitation the researcher sat in on one of the Sheerwater CMHC user group meetings. The user group had originally been set up by the co-ordinator of the voluntary organisation which provides the day services in the centre. The chair, though, now ran the group. He was a service user himself and had been elected by the members of the user group.

The members of the group were drawn from those who attended the day services provided by the voluntary organisation and the chair said that the monthly meetings were normally attended by between 10 and 15 people. They mainly discussed issues to do with the organisation and running of the Sheerwater CMHC and the day services provided by the voluntary organisation. The chair felt that the group had an influence in the way the centre was run. This was helped by

both his place on the management committee and the fact that the Centre manager attended the user group meetings. The Centre manager also had a role within the quality department of the East provider Trust. He had consulted and sought the views of the user group on the design of leaflets which were intended to provide information to people being admitted to hospital as mental health in-patients. The chair of the user group felt that the centre manager provided a link between the user group and the Trust and that he was able to represent the views of the group more widely within the Trust. The user group did not, however, have any strong link with the health authority.

The kind of user involvement that was present at both Sheerwater and Stackbridge CMHCs did not appear to be taking place at the two main in-patient facilities in the county - the Radley Unit in Trentham or the Buckler Unit in Riverbank. Such involvement of in-patients may be difficult at both Radley and Buckler because they will not be directly using the services on a longer term basis like those using the day services at Sheerwater and Stackbridge. Most people would tend to have short in-patient stays at the Radley and Buckler units which would militate against the organisation of longer term user groups with a consistent membership. Both units, however, do have day hospitals but the researcher was not aware of any user groups organised around these services. So whilst there did seem to examples of user involvement at the CMHCs in the county, it did not happen at all facilities. This was unfortunate because as one managerial interviewee acknowledged such participation at a unit level could form the basis for wider user involvement within the county as a whole:

> ET: '. . .each logical centre where there's mental health going on should try and address the user question in their own way, maybe by having a user group or maybe by occasionally having sessions where users can give their views. Once they get robust enough, it may be that different user groups on their own volition want to join together and provide a more wider perspective across different services and different localities. But I think that's their decision when they get there, rather than our decision on whether we think it's a good idea or not. '

It does seem logical that user groups should be set up independently rather than staff-led. Without strong pre-existing user or voluntary groups to encourage them, however, professionals and managers may be the only force within the county able to stimulate greater user participation. It could be argued that managers and professionals would have little incentive to set up groups which would be critical of them but the example of Sheerwater CMHC did appear to show that a group could be set up by a member of staff who could then subsequently hand over more control to users.

The next chapter will reflect more directly on the relationships between users and professionals and will examine the issue of user involvement and participation in their individual care and treatment.

Conclusion

This chapter has examined the findings at the managerial interviews in terms of the three main themes highlighted in earlier chapters of: the 'market' and the purchaser/provider split; psychiatric hospital closure; and user involvement.

In terms of the 'market' and mental health services, the changes introduced by the NHS and Community Care Act 1990 had had an impact on the relationships between the different organisations in the county which were created when the Act was introduced. There seemed to have been an initial separation and adjustment to each agency's new role. Part of this had also involved some experimentation with the use of competition in some areas such as residential services for older people with mental health problems. Despite a small amount of fundholders switching their contracts, however, the bulk of mental health service provision had remained with the two Trusts in the county. Thus, overall, there appeared to be little change in the patterns of most of the mental health service

provision that had existed before the Act. Increasingly, though, the managerial respondents had identified a tension between two conflicting strands of central government policy. There was the emphasis on the 'market' and competition to increase efficiency and effectiveness within the NHS. In the light of a number of high profile and tragic incidents involving those in contact with psychiatric services, however, there were also calls for greater collaboration between mental health agencies in order to improve the co-ordination of different elements of provision for individual users. The interviewees felt that these contradictory strands of policy sent conflicting messages to those working at the local level.

On the issue of the shift from institutional to community care, the respondents felt that the plans to close the large Victorian hospital in the county would in the future have a significant impact on local mental health services. By freeing up valuable resources the closure of Foxton would allow more localised and community based provision. The full effects of the closure of Foxton were not apparent by the end of the case study period because the closure was not yet complete.

Despite a high level of commitment to encouraging greater user involvement in mental health services and some examples of active user participation at the facility level, the initiatives being set up around user involvement in the county had yet to be fully implemented.

CHAPTER SEVEN - 'AT THE COAL FACE': USER AND PROFESSIONAL PERSPECTIVES

Introduction

The last chapter looked at the perspectives of managers in the purchaser and provider organisations in the county about mental health services and how they had been affected by the changes introduced by the 1990 NHS and Community Care Act. This chapter will examine the perspectives of the users and professionals who were interviewed for the study between August 1995 and May 1996. Thus this chapter will be examining the views of those who provide and receive mental health services 'at the coal face', a term used by one of the managerial interviewees to describe the actual direct provision of care and treatment to users by practitioners.

The chapter will examine both predetermined issues which were considered central to the study and thus included in the interview guides (Appendices B and C) and also themes which were highlighted by respondents themselves in the interviews. The former group includes the issues of: choice; user consultation and involvement; the impact of the 1990 Act; and the closure of Foxton. In the latter group are: user attitudes to professionals; medication; the problems of addressing a range of mental health problems; and improvements to the service. The chapter begins with the users' overall attitudes to mental health services before discussing specific aspects related to the 1990 Act such as choice or involvement. The overall views give some context to the specific issues related to the 1990 Act. As will be seen the general satisfaction with services helps to explain why the issues of choice and involvement did not subsequently receive a great deal of comment from most of the user interviewees. As with the previous chapter, although some of the other existing studies are referred to in this chapter the substantive

discussion of the findings from this research in relation to the literature is reserved for the next chapter.

Before the above themes are examined the chapter will give a brief overview of the characteristics of those interviewed.

Interviewee characteristics

Users

As outlined in Chapter Five there was a fairly even split between male and female respondents and three of the interviewees were from a minority ethnic group. Interviewees were not specifically asked for their ethnic origin so the above figure is based on an assessment by the researcher. The study did not aim to recruit a specific target number but it was felt important that at least some respondents were from a minority ethnic group to reflect the fact that in the county as a whole there was a significant proportion of residents from minority ethnic groups. Only two respondents lived in accommodation specifically set aside for people with mental health problems; one in a hostel run by a voluntary organisation and the other in a block of individual flats for people with special needs. Of the remainder, five lived alone and nine lived with either a partner or relatives in rented accommodation or their own home. Only one of those interviewed was employed. The majority were receiving social security benefits, one was retired and two classed themselves as housewives. As mentioned in Chapter Five, although the interviewees were not specifically asked their age, the overall range of ages of the users who took part in the study was from early twenties to early sixties. With most interviewees being in the 30 to 50 age range.

Six of the user interviewees could be characterised as shorter term users of mental health services having been in contact with services for less than a year. Within

this, though, the extent of service use varied. Most had first seen their GP, were then referred on the Community Mental Health Team (CMHT) and were in contact with a community psychiatric nurse (CPN) but there were two users within this group who had spent time in hospital, one of whom was compulsorily detained or sectioned under the Mental Health Act. Within the remaining group of 10 longer term user interviewees, who had been in contact with mental health services for over a year, there was a wide variance in the length of time people had been in contact with psychiatric services from just over a year to well over 30 years. All of these longer term users had spent at least one period of time as an in-patient in a psychiatric unit. Where quotations from users are used in this chapter individuals are identified only in terms of a letter (e.g. A, B or C etc.) and whether the person could be defined as either a long (L) or short (S) term user of services.

Professionals

In terms of the basic characteristics of the eight professional interviewees there was again a fairly even split in terms of gender with five males and three females. Four social workers and four community psychiatric nurses (CPNs) were interviewed. Seven of the practitioners were drawn from seven of the community mental health teams (CMHTs) for general psychiatry in the county. As mentioned in Chapter Five there were eight such teams in the county as a whole but one had to declined to take part in the study because it was felt that staff in the team did not have enough time. The final interviewee was a social worker working with the secure services at Foxton Hospital. Since the issue of Foxton and its closure was a major theme in the study it was felt that it would be useful to get the perspective on mental health services of a practitioner linked with Foxton.

The range of experience of the professionals was varied. At one extreme one of the social workers interviewed was about to retire after over 30 years' service. On the other hand, although he had previously been in various posts on in-patient

wards, one interviewee had been working as a CPN for only 18 months. Most had experience of working in mental health services in other areas of the country before coming to work in the case study county but the secure services social worker had spent all of his 20 year career working out of Foxton. The majority of practitioners had been working in the county for between four and 12 years. Although all met with users in a variety of settings including their own homes, three of the social workers and one of the CPNs were based at hospitals. Two CPNs and one social worker had their base at smaller community hospitals and the remaining CPN was based at a health centre. Quotations from professionals in this chapter are identified by a figure (e.g. 1, 2, or 3 etc.) and as either from a social worker (SW) or community psychiatric nurse (CPN).

Overall user views and attitudes to mental health services

In general those interviewed spoke positively about the care and services that they received. Whilst they did criticise specific aspects of care none completely condemned psychiatric services overall. These areas of specific comment and criticism are highlighted throughout this chapter. The generally positive attitude to mental health service provision could be explained by the role of professionals in the recruitment of interviewees. Professionals may have steered the researcher towards users who were complimentary about psychiatric provision and excluded those more critical of the service. As stated in Chapter 5, however, the method of enlisting participants through professionals was chosen because it was felt that participation in the study would be more likely if the researcher was introduced to users via someone who was already known to them. This approach was felt to be preferable to that of users being approached directly by an unknown researcher.

The main themes in users' overall attitudes towards mental health services are examined below.

Attitudes towards professionals

Overall users were complimentary towards the professionals that they were in contact with, particularly the CPNs and social workers. The following comments from four users were typical of those interviewed overall:

> KL: 'I receive good support from my social worker, good support from my community nurse. If I don't feel well I can get in contact with them.'
>
> AL: 'I find them to be very helpful. All of them, the nurses, the social workers and everybody to be very helpful, very understanding and very caring.'
>
> FL: 'Social services are very good. I get support from social workers if I'm not well. I have an emergency number I can telephone. The social services side in Riverbank are very good, extremely good.'
>
> CL: 'We get on really well. It's good company for me. If he (the social worker) didn't come I think I'd miss him on a Wednesday.'

Professionals were valued as a source of help and support but users also liked them as people and enjoyed their company. For many of those who lived on their own, the human contact provided by professionals was particularly important because they had very few other social links and relationships. The following quote from a user gives some sense of that isolation:

> AL: 'I don't have any contacts with people. The only contact I have with anybody is the neighbour next door. He went into Foxton four or five times himself for depression so he understands my position and he occasionally may talk to me or occasionally I may talk to him but more or less there's nobody. You today, other than the postman delivering or the free papers nobody comes to my door. It's just lonely.'

In this context the role of professionals became vital. With few other social contacts there was no one who would be alerted when people may start to become distressed. The fact that there were professionals who saw them regularly and checked on them was appreciated and valued by those interviewed.

Even when users were critical of an aspect of mental health service provision they were reluctant to be critical of the individuals working within it. Those users interviewed who had spent time in hospital were, for example, overwhelming critical of in-patient mental health services. The staff within these units, though, were often praised as caring and helpful. Despite the fact that many users would have liked more time to talk to staff, the workers themselves were not blamed for this because it was felt that it was their workload which prevented them from spending more time with them. Generally, it was the physical environment of the hospital, such as lack of privacy or the antiquated feel and state of disrepair, which was the main cause of complaint about in-patient services.

A rare instance of criticism of the nursing staff in a day hospital was quickly corrected by an interviewee:

> BL: 'Sometimes I think the nurses don't care'.
>
> Researcher: 'Why do you think that?'
>
> BL: 'Don't know really. I know they do, though, really'.

Even when one user spoke about being compulsorily detained and being forced to take medication he showed no resentment towards staff:

> AL: '. . . the force is not used to brutalise you or to hurt you . . . they may have to use force by pinning you down and giving you the injection. I don't call that force just for force sake, I don't call that brutish or brutality. I don't. It's just something that has to be done.'

Underpinning his attitude to staff, in common with others who were interviewed, was a fundamental faith in the knowledge, expertise and professionalism of practitioners. He trusted the judgements and decisions made by staff because of their experience:

> AL: 'Like I say their expertise, they are dealing with mental illness day in, day out, year after year. When you go into the hospital they can assess

> you . . . by listening to you, watching you, the way you behave, the way you act and dealing with you.'

Another user spoke about how she trusted practitioners and had faith in their knowledge as professionals:

> ES: 'It's like I'm going to them cause they know what they're doing, that's why they're psychologists. You come to me and ask me how to bake a cake, I'll teach you because I'm a housewife. I'm very much - right well that's you and I come to you and fair enough cause you know better than me. You know if they say the sky is black, you know okay the sky is black.'

One aspect of mental health services and one group of professionals, however, was singled out for criticism by users. Many users were dismissive of out-patient appointments with consultant psychiatrists. These were predominantly six-monthly appointments. Many felt they were just routine and of little real value since they were infrequent and short. The consultant, therefore, did not have enough contact with them to really know them and have a good understanding of their problems or circumstances. Three users:

> CL: 'I think it's a bit pointless cause I go there, I'm there for 10 minutes, have a talk and have a chat with the psychiatrist there and that's it. Then it's all over. You go away and nothing's really changed.'

> DL: 'I see a psychiatrist every six months. I can't really see the point but Joe (his CPN) makes me go. So I do it and just talk about how things are generally.'

> LS: 'I didn't really know what the purpose of going was . . . it's just that I came out of there thinking well what have I achieved. I've arranged for the kids to be looked after by someone, my friend's got the day off . . . I've done all these things and I've been in there 20 minutes and what have I done?'

Despite the comment of the last user above, the belief in professionalism and expertise of practitioners highlighted earlier still seemed to temper her criticism. Later in the interview she remarked:

> LS: 'I didn't see the need for yesterday (when her appointment with the consultant took place) but that's why they're doctors and I'm a housewife.'

Another user wanted to be seen regularly by a psychiatrist as she had been in an area where she had lived before. She felt that the psychiatrist in that area had been able to build up a relationship with her and a knowledge of her and her condition that had allowed him to able to detect when things may not be going so well:

> FL: 'I mean my last psychiatrist, I didn't have to tell him, he knew when I was not well whereas Dr X will just go by the notes and go by what various other doctors have told him. But I mean I don't always even see him which I think is terrible really. You get seen by junior doctors who aren't even qualified to be doctors and I know more about my illness that what they know about it.'

The key aspect that seemed to be missing for most users in their relationship with their psychiatrist was a sense of familiarity. They did not see their psychiatrist often enough to have the feeling that he or she had any in-depth knowledge about their problems or them as a person. When they did see them the meeting was not long enough for users to feel that the encounter was of any great benefit. It seemed routine and, to some, pointless.

This lack of regular contact may explain the different attitudes to psychiatrists on the one hand and CPNs and social workers on the other hand. The latter were seen more regularly by users, usually every two weeks. Users were able to develop a closer and more personal relationship with their CPN or social worker. This in turn may have meant that CPNs and social workers were more important to users and thus they may also have been more reluctant to be critical of them.

The lack of criticism of CPNs and social workers could also be explained by the users' perceptions of the researcher. Although the status of the researcher was explained to participants, a degree of doubt may have remained about his role. The researcher identified that he was from the University of Luton and not part of

the mental health services. Users may have still been unsure about the ability of the researcher to influence the provision of services. If any user felt that the researcher may be able to recommend the reduction of a CPN or social worker input, then he or she may be reluctant to be critical of an aspect of service provision that was highly valued overall even though there may be aspects which he or she did not like.

Of course, the alternative interpretation is that users were genuinely satisfied with their CPNs and social workers and overall this did appear to be the case. Other studies have also shown that the care provided by professionals working in the community such as CPNs and social workers is valued highly by service users (Rogers et al., 1993; Carpenter and Sbaraini, 1997). At the time they were interviewed all the users were 'in the community' and thus the interaction with CPNs and SWs constituted their main contact with mental health services. Users seemed satisfied overall with the services they were receiving at that time but, as has already been noted, this did not preclude criticism with aspects of mental health service provision that were more marginal to their day to day living. In the latter category was the less frequent contact with psychiatrists and also the past experience of in-patient mental health services which, as is noted in more detail later in this chapter, was viewed negatively by many of the user interviewees.

Medication

Medication seemed an important issue for the most of the users interviewed in the study. It was not a theme which was specifically included on the interview guide but it was an issue which many users raised and discussed. As the researcher carried out more interviews it was an issue that he increasingly asked people about. Only two of the 16 users were not taking any form of medication at the time of the interview. Views of and attitudes towards drug treatments were mixed and the role that each person felt drugs played in their well-being varied. For

example, there were those that thought that without the continued use of medication it was likely that they would relapse or become 'ill' again. Two users:

> AL: 'I can survive on the slightest doses but as soon as I stop completely that's it . . . my second breakdown was through stopping medication. And all the others that I had including the last one and the one before the last one, it's all through the same thing, stop taking the medication.'

> OL: 'Some people are on medication and they are still talking to themselves, hearing voices. Those type of things only happen to me when I'm sick. Once I take my medication nothing like that happens to me. But as soon as I stop, I have a relapse and those kind of things come up on me again.'

Others were less sure about how helpful their medication was. Two users:

> CL: 'But the medication that you're asking about, it's hard to say whether it does any good 'cause like when I haven't been on it I haven't felt much different to when I am. So it's just that it might be doing some good but I'm not noticing it. I don't know.'

> BL: 'I'm not sure. It's supposed to help my mood swings and like I haven't got high for a while but I don't really notice.'

Between these two positions there were those who identified both benefits and drawbacks to the drugs they were taking. For example one user commented:

> PL: 'Yeah the tablets help me. They relax me, they help me sleep but they're knocking me out all the time.'

Others had taken drugs in the past which had side effects such as muscle spasms or hallucinations. It had therefore taken some time before they found drugs they were happy with or which 'suited' them. None of the users interviewed completely dismissed their medication as wholly unhelpful. One user did feel, though, that there was an over-reliance on drug treatments within mental health services:

> FL: 'It's all drug orientated. Too much in the mental health service is all drug orientated. You know you'll take this drug and you'll take that drug and if you don't take that drug then they'll prescribe another one for you . .

> . I think in a realistic world people with mental health problems should have access to psychotherapists and all that sort of thing which they don't, they are just given rugs.'

This interviewee's comments that the service was 'drug orientated' was a response to being asked whether she felt she had a choice about the kind of treatments and services she had access to. The responses of other users and the attitudes of professionals to the extent to which there was user choice within mental health services are examined below, as the chapter moves on to discuss issues more closely related to the 1990 Act.

Choice

A theme of both the last Conservative government's policy in general and specifically the changes introduced by the NHS and Community Care Act, at least at a rhetorical level, was increased choice for consumers or users. A specific aim of interviewing users in this study was to attempt to explore what choice might actually mean for users of mental health services and the extent to which they felt they had a choice of the treatments and service that they could access. Professionals were also asked about the extent to which they felt users had a choice.

Only a few users talked at any length when asked about whether they felt they had a choice within mental health services. In the context of the majority of interviewees' general satisfaction with mental health services, most did not feel there were alternative treatments or services that they wanted to access. If there were aspects of their lives that they were unhappy with or they felt they would like more choice in, these were often areas that were beyond the scope of psychiatric services. For example, for some users an increase in social security benefit levels and therefore more money would have allowed them greater freedom or choice in their lives. One user said that a lack of money placed

restrictions on how often he listened to the radio or watched the television. He explained that he had to be careful about how much electricity he used:

> AL: '. . . the constant worry of whatever I use, this is all electric, whatever I turn on, whatever I use, whenever I use anything I'm worried about the bills because I haven't got enough money coming in for my expenditure.'

To an extent, in undertaking the interviews the researcher may have assumed that mental health services played a greater role in users' lives than was perhaps the case. There may have been a tendency to see people primarily as users of mental health services and thus to over-emphasise the importance of psychiatric services. Some people's contact with mental health services may only consist of seeing a CPN once every two weeks. In this context a focus on choice within the context of mental health services may have failed to take into account wider issues and considerations in people's lives. There did not seem to be the expectation from most users that it was necessarily the responsibility of mental health services to address every problem in their lives. This is an important consideration in explaining why the concept of greater choice within mental health service provision did not receive much comment from users. It may be that their expectations about what psychiatric services are able to offer them or should offer them were limited because they did not perceive mental health services as playing as important a role as perhaps the researcher had anticipated.

A few users did make some comments about choice within mental health services. The user highlighted earlier (FL) clearly felt that choice was limited and that drugs were the only real treatment on offer. As she mentioned, she wanted access to psychotherapy but had never been offered it. She felt that it was generally offered to those with less severe mental health problems, such as panic attacks or agoraphobia, rather than those with severe and long term problems. The reason for this, she thought, was that there were not enough resources to offer psychotherapy to everyone with a mental health problem. In the case of those with severe problems she felt that it was left to the social workers to talk to people

and 'find out the social side of the problems'. She felt, though, that the social workers 'have only got so much time to spend with people.'

For another user, choice was limited in terms of day care provision. He was generally reluctant to use existing day services and centres because he preferred to be on his own. He did not like mixing with other people and tried to avoid situations where he thought he might have trouble or clash with people. Both he and his CPN wanted to try to arrange for him to do something at home so that he could occupy his time during the day. It was proving difficult, though, to get the rehabilitation or day services to organise some form of domiciliary occupational therapy.

In the case of another respondent the discussion of choice was linked not so much to a lack of alternatives but the inability actually to express his choice and for it to be recognised by the professional he saw. He was currently doing some voluntary work on a conservation project which he enjoyed but his long term goal was to get back into paid employment. The social worker that he saw, however, seemed only to suggest other voluntary work:

> CL: 'Well I haven't said anything to him, I suppose I should, but he does mention voluntary work a lot . . . He says he can find me other voluntary work to do but that's not what I want. What I really want is to get back to work. I've been out of work now for six years, you see, quite a long time.'

The social worker may have felt that he was not yet to ready to work but the user did not feel able to express what he really wanted to do. This particular example cuts across the theme of user consultation and participation which is explored more fully in the next section of this chapter. The user did not feel able to assert his particular preference and the professional, although he may have felt he was being helpful, does not appear to have fully consulted with the user or be fully aware or what the user wanted. The chapter will return to this theme in the next section.

For two of the interviewees who had been compulsorily detained in hospital the concept of choice clearly had a different meaning. By definition neither was given the choice of whether they wanted to go into hospital or not. Neither, though, seemed resentful about having this choice taken away from them. Looking back both felt at the time they were 'not themselves' and therefore needed help. Both felt that the practitioners involved in their detention were using their professional judgement to do what they saw as in the best interests of the user. They summed up their feelings on being compulsorily detained as follows:

> AL: 'I didn't feel I had any choice about what happened. But if they'd left it to me what would have happened to me? What would have become of me? What I do say and I keep saying is that they have to be cruel to be kind. And I've got no truck with that. It's not pleasant at the time but I've got to truck with that. I accept that.'

> CL: 'I was actually forced to go in there 'cause they said I needed to go in there and I didn't think I did. I didn't think there was any point but I dunno, that was their professional opinion, they've got their professional opinion, they're doing their jobs, what they see as right.'

The professionals in the study were also asked about the extent to which they felt users had a choice within mental health services. Two felt that users were given choices but their illustration of this seemed to be based on quite a narrow conception of choice. It related to where people were seen by professionals. The two, both CPNs, commented:

> CPN2: 'We offer them a choice whether they want us to do a home visit or if they want to come to a clinic for their treatment.'

> CPN6: 'People are given choices of where they would like to be seen . For instance we give them a choice of whether they would like to come and see us here, choices to see us at home or at the GP surgery. So I think there are more choices being made available.'

Obviously this says nothing about the nature of the actual treatment that users are offered. If the user above who complained that services were too drug orientated

were given the choice of whether to receive her medication at home or at a clinic, it would still not satisfy her that there was any real choice within mental health service provision. In identifying areas of limited choice another CPN also pointed out that people could not always be seen at a time which would be most convenient for them. Although most CPNs did evening visits, he felt that seeing people at weekends was more problematic. So whilst people may have had some choice *where* they were seen, there may not always have been a similar flexibility about *when* they were seen.

Examples of perhaps more extensive choice being offered to users was given by a social worker. She felt that the 1990 changes that had given her the ability to purchase on behalf of users had actually allowed people more choice in terms of the kind of accommodation they could live in. Rather than being faced with a limited range of Local Authority run facilities, by having some influence in how resources were allocated, she felt that it was easier to find places for people in hostels run by voluntary organisations. In these facilities she considered that people were given more freedom and independence because they offered a less structured and regulated environment. This was particularly useful for younger users who wanted the ability to go out and socialise.

Another social worker felt that in some circumstances the changes introduced by the 1990 Act could actually be identified as limiting the choice available to users. For example, a user from the town of Trentham after being admitted to and spending a long period of time in Foxton may not want to return to Trentham. Since Foxton borders another county the person may prefer to go and live in one of the smaller towns or villages surrounding Foxton which are actually in this other county. Under arrangements in place after 1990 this would mean that the person would become the responsibility of another Local Authority and another mental health service. If the person did decide to live in another county this would have resource implications and thus the social worker felt that it was now

more difficult to arrange. The other area may not want to accept the additional expense of this person moving into the county. The changes had, the social worker argued, made it less easy for people to move around and therefore have less choice about where they lived.

Overall then professionals' views were mixed about whether users could exert choices and whether this situation had been improved by the 1990 changes. There seemed to be an indication that the changes within social services may have a greater role in increasing users' choice and access to alternative services. The 1990 changes had devolved purchasing and therefore control over resources to a lower level within social services than was the case in the health service. In the case of the county under study case managers in social services were responsible for purchasing packages of care. They were the direct line managers of the social workers who were in contact with users. Social workers were much closer to purchasing decisions and able to 'lobby' their case managers for particular packages of care, for example the placement of someone in a particular residential setting. Within the health service a CPN who had most contact with a user was much more distanced from purchasing decisions. Managers within the HA ultimately decided where resources would be allocated and, therefore, what services would be provided to users. These managers were within separate organisations and contact with providers would be through Trust managers. So within the health service there would be little contact between the purchasers in the HA and the professionals who interacted with users.

The issue of choice and users' actual expression of those choices is crucially linked to the issue of consultation and involvement. The example was highlighted earlier of the user who wanted to get back to paid employment rather than just continue with the voluntary work his social worker proposed. This illustrates that even if users do feel there are choices they want to make, if they are not adequately consulted by professionals or involved in discussions about what they

want, then it is unlikely they will be able to actually make those choices. The issue of user consultation and involvement is explored below.

User consultation and involvement

Users in the study were asked about consultation and involvement between themselves and professionals in their care and treatment. None of the users interviewed was or had been part of the limited number of user groups in the county. They did not have any experience, therefore, of the extent to which user involvement was taking place at a planning or managerial level. In terms of their experience at the treatment or care level the majority seemed content with the level to which they were consulted about or involved in decisions about their care. Most again had very little to say about the issue. This is perhaps a reflection of the fact that most respondents were satisfied, overall, with the services and care they were being offered at the time. As they were satisfied with the services they were getting, they were also content with the extent to which they were involved in decisions about their care and did not seem to feel there was any real need to be more involved. For those that were generally satisfied with the services they were receiving, greater involvement almost seemed like an irrelevance.

The few, however, who were dissatisfied with aspects of their care felt that they would like to be consulted more or did not feel they were involved enough in decisions about their treatment or the services they could access. For example, the user who felt that she would like access to psychotherapy rather than simply being given drugs did not feel that she was asked about what she wanted or involved in decisions about her care:

> Researcher: 'How involved do you feel with what is offered to you, what's provided to you?'

> FL: 'I think the treatment that you're offered, it's just a case of if you don't feel well take this medicine, take that medicine and go away basically. Just take medicines to keep you quiet.'

Similarly the user who wanted paid employment rather than just voluntary work would have liked to have been able to express that to his social worker. In that sense he wanted to have more say in the kind of things he was offered.

Those who wanted more say and involvement were very much in the minority amongst those users interviewed. This is not to say that those who were generally positive about their level of input could necessarily be viewed as active participants in decisions about their care. They gave the impression that they were satisfied with what they were offered and did not really consider the need for anything else. Most did not seem to have clear expectations about what help they wanted when they first came into contact with services and were then subsequently satisfied with the services and level of support that they were offered. The following quote from a user seems to sum up how many of those interviewed did not have clear expectations of what kind of help they wanted when they first come into contact with services. Here she describes going to see her GP:

> ES: 'I just literally went to him when I went to him on the Tuesday. As far as I was concerned it was me or the kids. You have to do something. I don't know what you're going to do but you've got to do something. I couldn't cope, I was crying. I'd just lost it totally. Absolutely lost it . . . But I went there with the feeling; "Argh you've got to help me. Right put me on to the right people".'

Clearly, by definition, people are in a state of distress when they first come into contact with mental health services. Users will not systematically assess what their needs are and what specific help they need. In a distressed state their expectations may not be clear and they may just be grateful for whatever help they are offered. Within that, the scope for actual involvement and participation in what they are offered may be limited but this did not appear to be of primary

concern for most users interviewed. If they were content that what they were offered had helped them to get over a period of crisis, they did not seem to be overly concerned with whether they had been fully involved in decisions about their treatment or an active participant in their care. This is not to say that such involvement would not be important to other users. The numbers of those interviewed clearly means they cannot represent a definitive statement about what is important to all users of mental health services as a whole. What it does suggest though is that active participation is not always of primary importance to every user. It may become more important if users do not perceive that they are getting the services they want.

All the professionals interviewed were in favour of increasing user participation in mental health services. They were divided, however, in the extent to which they felt that user involvement was actually a feature of services in the county. Some thought users were actively involved but others were less convinced. Three professionals who felt that there was user involvement within the local psychiatric services:

> CPN6: 'We try to involve users and carers at an early stage. For instance on discharge from hospital we involve users and relatives at an early stage and get people to agree to their care plan so they know what is expected. The Care Programme Approach stipulates that people have to agree to, and sign, the care plan.'
>
> CPN2: 'We involve clients and relatives on a one to one basis. When we get the reviews done I go to the reviews with the client.'
>
> SW3: 'There is an advocacy worker who comes every Wednesday (to the ward at the Radley Unit) and welfare benefits worker who helps patients with their money.'

Two of the practitioners above specifically related user involvement to the undertaking of Care Programme Approach (CPA) reviews and care plans. It is notable that the first CPN relates involvement within the CPA to getting users 'to agree to their care plan'. This suggest that users are merely agreeing to an agenda

set by professionals and gives no indication that users themselves have any active role in setting out their programme of care and treatment.

Another CPN was more explicit in identifying the lack of participation by users within the CPA, particularly those who had had contact with secure services:

> CPN7: 'Patients are in the unfortunate position of having a lot of decisions made for them because they are sectioned, they didn't want to be in the secure unit (at Foxton) in the first place. They are shown the decisions and they have rights but the nature of the client group is that decisions are made for them.'

There was an equal number of professionals who did not feel that there was a significant level of user involvement within the local mental health service:

> CPN5: 'I still think it is service orientated. I think we still direct clients to the services available and not necessarily identify individual needs. So I still think we've got lots of work in that direction.'

> CPN7: 'If you look at people coming out of Foxton they are not used to asking for what they want or the basic information. If you look at the people in the community when they go to see the consultant or doctor they haven't always got their thoughts together and they come out and say I wished I'd asked this, I wished I'd asked that. Even with us sometimes I have to discipline myself to actually ask the client if there is anything you want to ask me. I think it's something that will develop over time when people start to realise how much power they have.'

> SW4: 'I think involvement of users at the moment in the county is minimal. It's still all professionally-led, it's got managers who make the decisions and the users get no say. There are not that many user bodies, we've got an advocacy service in Trentham and across the county. But I don't think that users are really listened to. There is no forum for example for users really to have a voice. Nobody's set up that, not really.'

The social worker quoted above was also particularly adamant that having a particular voluntary group in the county representing users' views was not a substitute for the direct involvement of users themselves:

> SW4: 'They always keep claiming that they are the voice of the user. They are not. They are a very active, noisy professional voice, of I think professional busy bodies, unqualified people who feel that they know exactly how mental health people should be treated. When you look into their background, you know why should they? And what have they done? They don't work with these people necessarily but they feel they have a strong view.'

The professionals interviewed in the study were split between those who did believe users were involved in local mental health services and those that felt that involvement was minimal. The latter group did identify that there was lack of local initiatives, groups and forums at which users were able to inform the planning and commissioning of mental health services. This was also identified in the last chapter which focused on the accounts of local mental health managers in the purchaser and provider organisations.

The closure of Foxton hospital

The professionals interviewed in the study were asked what they felt would be the impact of the closure of the large psychiatric hospital in the county, Foxton. This was because, as identified in Chapter Two, this was a significant theme within the thesis as a whole. In contrast with the managers, whose views were outlined in the previous chapter, the professionals made no comment about any positive aspects of the closure, such as the freeing-up of resources for new services or modernised facilities. Their concern was that with the closure of Foxton there would be a number of difficult to manage people with severe and long term problems who would not be catered for within the county's mental health service provision.

> CPN7: 'It's sad because it's hard to see at the moment what's going to happen to these institutionalised patients . . . There's a hard core of chronically, hard to manage people, happily managed on a two person ward (i.e. a ward run by two members of staff) but in the confines of Foxton.'

> SW4: 'There is a large collection of people I feel, there is a rump of people who cannot live in the community . . . Foxton is almost two years to the day from being closed and it's still a desperately overused facility and if it opened it's gates tomorrow it would be full again up to the 800 mark, whatever it was because there is just a mad queue, perhaps that's not the right word, a long queue of desperate people trying to get into a hospital setting.'

> CPN2: 'My worry about closing places like Foxton is that they are a few patients that need that kind of environment especially patients who've been there for quite a long time and to expect them to come in cold to the community unless they have a lot of support . . . my own concern is whether they'll cope.'

These professionals felt that even after Foxton had closed, this 'hard core' or 'rump' of people would still need the kind of intensive care and protective environment that it had provided. They did not feel that there were clear plans to set up this kind of provision. Another CPN was fearful that without adequate services to replace those at Foxton practitioners in the community like himself would face increasing pressure:

> CPN5: 'Unless they provide the appropriate services it's going to block beds which in turn is going to put more pressure on the community and the likes of myself to provide service in the community.'

The social worker quoted above was particular scathing about the closure of Foxton and what he felt was the complete rejection of any form of institutional care within current mental health policy:

> SW4: 'What it seems to me and a lot of my colleagues is that we need a mixed economy of care. We don't want to go back to the days when the only place you could go to was a large psychiatric hospital but neither do we want to look forward to a day when it's impossible to go to a long term psychiatric facility and that I'm afraid is where we are going to. We have to pretend and it's a pretence, a faddish, politically correct pretence that there is no such thing as long term mental illness. Or if there is it can all be very well looked after in the community.'

This particular practitioner had spent all of his 20 year social work career based at and working out of Foxton. With this in mind it would perhaps be easy to dismiss

his views as merely protective of his work and that of his colleagues. It could be interpreted as a defensive reaction to the fact that an institution in which he had spent much of his working life was now seen as irrelevant to the service. Yet this would be to ignore the very real and practical considerations he, and the other professionals raised, about how to cope with the minority of very severely disturbed people who for the sake of their own or other people's safety may not be able to live independently in the community. The dilemma is perhaps best summed up by the social worker himself:

> SW4: 'There will always be the terrible instances with the Clunises[1] and people like that . . . I think you've got to ask the question would you really want a whole group of people who've been up to very dangerous things living next door to you. I would say to anyone who thinks that everyone should be out in the community, the most dangerous people in the community must be looked after by you. Because you're the people who insists it can be done. 'Cause I know I can't do it.'

Such comments could be seen as dramatic and scaremongering. The social worker clearly believed, however, that there was still a minority of people who will need the kind of intensive care which has been provided by the large asylums. Whilst he felt that this may not be an argument for keeping them open, he did believe that alternative, appropriate provision needed to be available.

Only two users interviewed for this study had spent any time in Foxton hospital. One of them had only spent a short amount of time there and said he had no complaints about either the hospital or the staff. The other had last been in Foxton 20 years ago. He had spent nearly 13 years there as patient. Sometimes he stayed overnight and at other times he was allowed, on leave, to go home at night. He got on well with the staff and had liked it. Asked about it's impending closure he simply said:

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[1] This refers to Christopher Clunis, a mental health service user who, as was widely reported in the media, killed Jonathan Zito outside a tube station in London.

DL: 'It's a shame. It was a good hospital and I'm not sure what's going to happen to the place.'

The 1990 Act and mental health: listening to money not people?

A significant factor in interviewing users with long term experience of mental health services was to try to discover whether they had noticed any changes in provision since the introduction of the 1990 NHS and Community Care Act. Ultimately, though, the users interviewed in the study claimed not to have noticed any significant changes in mental health services since the introduction of the Act. This would seem to confirm the suggestion by most of the managerial interviewees in the study that the 1990 Act would not have had a direct impact on users and the services they receive.

When asked directly about their impressions of the impact of the changes introduced by the 1990 Act, the professionals interviewed gave a variety of responses. The one consistent theme within their responses was that they sensed there was more financial stringency and a greater focus on money and costs within the service:

CPN2: ' . . . it is more difficult now to ask for things . . . Even minor things like folders for patient notes or writing paper. We seem to have to justify whatever we want.'

CPN5: 'I think it's impinged in that more and more demands are being put on us without necessarily more resources and market forces are much more money orientated, not necessarily for all the right reasons.'

CPN7: 'It's made staff much more aware that money does have a big say in a lot of things.'

When asked for examples of this the last CPN, who worked mainly with people discharged from the secure wards at Foxton hospital, mentioned the issue of extra contractual referrals (ECRs) which was highlighted by one of the managers in the last chapter. These are beds which are used by hospitals and units outside the

county when they are unable to find an appropriate bed for people within their own contracted service. The CPN said that the number of beds designated as ECR beds on the secure wards at Foxton had been increased despite assurances from management that the first one would be the only one. Staff had also been assured that in the case of pressure on beds within the county, patients within ECR beds would be sent back to hospitals within their own HA. He felt, however, that that had not been the case and as a result the catchment areas within the county tended to lose out when there was pressure on beds. This was because the ECR beds were a source of extra revenue for the Trust.

One social worker, who was shortly to retire after 30 years in mental health social work, felt that financial constraints and rationing had always been an intrinsic part of social work. The 1990 changes, though, made the rationing process more explicit. They had made it clear that, using care management, social workers would have to assess need and provide for it within the available resources. Although he argued that this was what essentially social work had always been about, it was now more transparent and openly acknowledged.

Another social worker summed up the changes as follows:

> SW4: 'What we've had is right wing dogma dogging what is essentially a left wing service which has brought about all sorts of problems. They've been trying to, if you like, bring in a few right wingers to make the whole system better. Unfortunately I don't think that works.'

In talking about the way that those working within the mental health had reacted to the imposition of these ideas he suggested there was a certain amount of absorption and adaptation. The interview was carried out in April 1996 and he also alluded to the, then, approaching general election. He suggested that some within the service had their eye on a change in government which may see a shift in emphasis away from the more overtly right wing inspired aspects of the 1990 Act such as markets and competition:

> SW4: 'People have a strong vocation. They see the winds of change and they sort of bend with them a bit and they move slightly in the right direction but they don't move too far. They tend to resist, waiting for the wind to change direction which I suppose we all think is going to happen within the next year.'

More positive aspects and advantages of the changes were highlighted by respondents. Two interviewees, both social workers, commented on the fact that the purchaser/provider split had encouraged a greater concentration on needs:

> SW4: 'I think there are some good things about it. I think having a needs led service is far far better than having a service that is resource led by somebody in an ivory tower who says this is what you get, hope this is of some use. It's much better for us to say this is what we need , this is what this person needs so this is what we want. I think that is a real positive thing about it.'

> SW3: 'The ability to purchase services has made a big impact. Having the money has encouraged a more client centred service, especially in terms of housing. Previously we had been limited to accommodation run like old people's homes with little freedom for clients. They were given pocket money of £12 and unless you are very ill that's no good if want to go out and socialise, especially for younger clients. Now there are services . . . which are more suitable . . . There are also employment services and industrial training such as computer courses.'

These social workers had clearly felt that the purchaser/provider split in social care had been beneficial by giving them more say in how the money was spent. This had allowed them to purchase services and to place users in accommodation and facilities which were much more appropriate to their individual needs and requirements.

'Pulled in different directions': addressing the range of mental health problems

In asking professionals what were their chief concerns about services and their work, an issue that was highlighted by most of the CPNs was the tension between

addressing the needs of a range of people with mental health problems. They agreed with government policy which gave priority to services for those with severe and enduring mental health problems or, in diagnostic terms, those with conditions such as schizophrenia and manic depression. They were also aware that there is a considerable number of people with what specialist services would define as less severe problems such as those with milder forms of depression or those suffering from anxiety or panic attacks. The general expectation was that those with less severe problems would be dealt with by primary care services. CPNs were aware, however, that GPs and other members of the primary health care team did not always feel able to cope. Consequently, the CPNs felt that both they as individual practitioners and their Community Mental Health Teams (CMHTs) were often under pressure from those in primary care to see people with less severe mental health problems despite government policy identifying the severely mentally ill as the priority for CMHTs. Three CPNs:

> CPN5: 'We feel at times we are being pulled in different directions. A couple of years ago as CPNs we were actually asked to go and sell ourselves to GPs which is what we did and from that we actually got a large proportion of referrals for the "worried well", as we term them. Obviously recently that has been changed and the government is putting much more emphasis now on enduring mental health. It's left a gap between what the GPs want and what the government want.'

> CPN6: 'The main issue I find is the confusion that arises from the demands from GPs for us to sort of provide a response to people who are probably less seriously mentally ill. I'm not saying they haven't got a place in what we do but there's that conflict as opposed to the seriously mentally ill that we are supposed to be focusing on.'

> CPN2: 'We have contact from health visitors and GPs and I think they want us to get involved without actually referring but that's not how the system works. It has to come through a letter or a phone call to the team and we as a team have to make sure it's appropriate because our priority is the severely mentally ill.'

The tension was more marked in the west of the county where as the first CPN above identified they had previously been 'asked to go and sell ourselves to GPs'.

This related to a decision within the Trust, which had come from the Chief Executive, that CPNs should be locality based and more closely aligned with primary care and GP practices (both fundholders and non-fundholders). This had involved each CPN being assigned to liaise with a particular practice or group of practices in one area. The CPNs were now experiencing difficulties in attempting to draw back from that in order to comply with government guidance that insisted they target those with severe and enduring mental health problems. One CPN commented:

> CPN6: 'Since we've been locality focused we see them (the GPs) more often and they have become more aware of our existence so they tend to refer more people to us than perhaps they would have done two or three years ago.'

The locality and more primary care orientated focus which the Trust had sought to cultivate had raised GPs' expectations that they could draw on CPNs as a resource to deal with those with less severe mental health problems. In attempting to assert their priority as those with severe and enduring problems CPNs were caught up directly in the tensions between primary and secondary care. One CPN remarked:

> CPN5: 'Whilst I have every sympathy with GPs that doesn't help me as a practitioner because they will send numerous referrals through and if either I or the team reject them then they get quite agitated.'

Another acknowledged the pressure that GPs themselves were under. Mental health was only one of the areas they had to cope with and they did not always have the capacity to deal with it effectively:

> CPN6: 'The GPs haven't got the time or the resources to deal with these issues.'

Despite this CPNs felt that with limited resources they could not allow themselves to be diverted from targeting those with the most severe problems. Deciding where to draw the line between who was and who was not severely mentally ill

was, though, problematic. Those that present to primary care may not initially appear to have problems of sufficient severity to warrant access to specialist services. Yet the professionals, both CPNs and social workers, felt that in some cases if their problems were not addressed adequately at that stage they may go on to develop more serious or longer term problems and so they, as professionals, could not cut themselves off from primary care altogether:

> CPN5: 'I do appreciate it is the preventative aspect of the work that is very important bearing in mind the Health of the Nation guidelines about suicide risk and so on. So there is that element.'
>
> CPN6: 'There is a proportion of people who because of stress factors today are having to go to the GP. If the GPs can't deal with that . . . my concern with that is that eventually these people could become chronic if not dealt with at an appropriate stage.'
>
> SW4: 'You can't solve everybody's problems but we need to identify those who if not treated earlier are going to develop significant problems later on.'

Two CPNs suggested that the provision of greater numbers of counsellors within primary care could be a means of addressing the issue of those with less serious mental health problems. This, they felt, would allow CPNs and CMHTs to concentrate on those with severe problems. Given, however, that greater numbers of counsellors would require more financial resources they seemed pessimistic about it being an immediate possibility. An alternative proposed by one of the CPNs was to increase GPs' awareness of other resources such as support groups, drop-in centres and counselling services run by voluntary organisation towards which those with less serious mental health problems could be directed.

Improvements to the local mental health service

Both users and professionals were asked about what ways they felt services could be improved or what other types of provision should be made available locally. There were no consistent themes amongst the responses from the few users who

highlighted possible improvements to local mental health services. What emerged was a series of individual suggestions. Areas for improvement that have already been highlighted in this chapter were: greater access to psychotherapy; home based occupational therapy; and the opportunity to take up paid employment. Another user described what she saw as the need for a facility that allowed people to recover from periods of distress without necessarily being admitted to an acute unit:

> HL: 'If there were places like, say, if you didn't feel too good and you could just go for a week and you could talk to someone and you could have the constant support on hand, you wouldn't be dished so many drugs out, you'd come back you'd feel a lot better. I'm making this sound like a holiday farm, a holiday club but if there was somewhere in between a hospital and care in the community because hospital is too institutionalised and to get into hospital nowadays you've got to be sort of raving off your head, you've got to be sectionable whereas if you're not sectionable nowadays they won't admit you into hospital.'

This suggestion was also echoed by one of the CPNs, who commented:

> CPN5: 'As the large institutions close more pressure is going to be put on the acute beds but they are not the appropriate places for people with enduring mental health problems. So I think there has got to be, I wouldn't call it an institution, but some sort of refuge where people can go to who don't necessarily need the acute beds, a bridge between being out in the community and being in hospital.'

The user above clearly felt that existing hospital provision was not acting as a place of refuge that allowed people to recover in periods of crisis. As noted earlier other users in the study had been critical of inpatient mental health services and found that the environment had not been relaxing or conducive to a speedy recovery. Here three users comment on the hospitals in both East and West of the county:

> DL: 'It's very sort of antiquated. You go down for dinner to a dining room and you stand all in line. It's like 'One flew over a cuckoo's nest'. You stand in a line and you're given your food and some of the staff aren't very nice, the cooks and that, they just sort of dollop it at you. And when

you go and get your medicine you go to a little hatch which is so old fashioned. I mean you shouldn't have to queue up all at a little hatch and get your medicine and that.'

JL: 'They've got sort of little rooms. One room that you're allowed to smoke in and when you've got about seven or eight people in a room half this size, like six by 12 or something. I mean it's very smoky and the extractor fans weren't working, the views out the window were terrible. You looked out on to a concrete, I mean you looked out onto nothing. You looked out the windows and the windows were filthy. They hadn't been cleaned and that.'

CL: 'Oh it was a terrible place. It destroys you, there's nothing to do in there. It's so boring. That's the main problem . . . you feel like a zombie there cause you've got nothing to get on with, nothing to do. . . It's not a good idea to keep people in there for too long ' cause I've found each time I was in there . . . It took me six months to recover from the place, all the medication I was taking in there and the way I felt when I came out. It takes about at least six months to recover again, to feel normal you know and forget the place you've been in.'

Similar negative views about in-patient mental health services have also been expressed by users in other studies (McIntyre *et al.*, 1989: Rogers *et al.*, 1993). Asked how the hospitals could be improved the users suggested that they should be redecorated and modernised. It was also felt that there should be more activities for people to do during the day.

In terms of what professionals felt could be done to improve local mental health services, there were two common themes. The first was related to the problem of demands to address the full range of mental health problems discussed earlier. The CPNs suggested that clarification should come from their own managers and those in the health authority to those in primary care that the priority for CMHTs was those with severe mental health problems. The second common theme was that the service was in desperate need of more financial resources to increase the number of staff available to support people with mental health problems.

Among other suggestions two CPNs felt that, both in terms of quantity and content of provision, day care was an area that could be improved. One thought that more day places were needed and the other highlighted the need in Trentham for less structured facilities. She argued that within existing provision people had to be involved in organised activities. Whilst that suited some users, there were other people who just wanted somewhere that they could go to on a drop-in basis to have a chat and a cup of tea.

Two other individual suggestions related to the management and operation of the specific services the professionals were working with. A CPN felt that his CMHT should have a team leader to provide line management for the CPNs. Social workers had a senior care organiser but CPNs did not have an equivalent. Within the team there was a G grade CPN but nothing above that before the middle management level in the Trust. The CPN wanted more immediate guidance and support from a manager who was more directly involved with the provision of services. He felt that the middle management within the Trust was more distanced from the operational side of mental health services. This also relates to the earlier discussion in this chapter about the differences in purchasing between the health and social services sectors. Some social workers had felt more able to influence the purchasing of packages of care because their immediate line manager had direct control over the allocation of resources. According to this CPN, the lack of similar direct contact with a manager in the health service was problematic because he did not have the direct support of, and influence with, a manager more closely involved with operational issues.

Another CPN felt that there needed to be a local agreement about the procedures involved for bringing people back into hospital under the supervised discharge arrangements. Under new supervised discharge arrangements introduced in 1996 an assigned key worker was given the power to convey a person back to hospital if they felt this was needed. This CPN argued, however, that there was no set

arrangement locally for how this should or could be done. He thought that it needed to be established, for example, whether he could call on a team of nurses physically to get people into hospital if he felt unable to do it on his own.

Conclusion

This chapter has examined the findings from the interviews with users and professionals in terms of the main themes of the thesis.

In terms of the introduction of the 'market' into mental health services, as predicted by the managerial interviewees, there seems to have been few changes which made a direct impact on users and the services they received. More changes had been noticed by professionals. These were mainly in terms of greater financial stringency within their organisations. Few felt, however, that the basic nature of their day to day work had been affected by the 1990 Act. For CPNs a noticeable development in recent times had been greater demands by GPs for them to see people with, what they often felt, were less severe mental health problems. With GP fundholders control over parts of the mental health budget this could be translated into financial pressure on the trust. The demands for more CPN input at a primary care level was not purely, however, related to fundholding since such demands also came from non-fundholders. The pressure from primary care created a dilemma for CPNs because government policy had clearly stated that as members of CMHTs their primary focus should be on those with severe mental health problems. Hence CPNs often felt they were being 'pulled in different directions'.

The issues of user choice and user consultation and involvement were not the subject of much comment by user interviewees. Both greater choice and involvement seemed to be particularly relevant only to those who were dissatisfied with a specific aspect of mental health service provision.

Professionals while committed to both increased choice and involvement were not always in agreement to the extent to which either were a strong feature of psychiatric services in the county.

The previous two chapters have set out the main findings and themes from the interviews with those involved with mental health services in the county. In the next chapter these findings will be drawn together and discussed further in relation to the existing literature which was examined in the opening chapters of the thesis.

CHAPTER EIGHT: DISCUSSION

Introduction

The previous two chapters presented the findings from the interviews carried out for this study. Chapter Six examined the perspectives of the managers in the mental health purchaser and provider organisations in the case study county. Chapter Seven focused on the interviews with professionals who actually provide mental health services 'at the coal face' and the users who receive those services. This chapter will attempt to draw these two sets of findings together and discuss them in relation to the existing literature which was the focus of Chapters Three and Four. It will do this by revisiting the two major themes which were addressed in each of these chapters. Firstly, this chapter will look at the issue of the 'market' changes introduced by the NHS and Community Care Act 1990 and its impact on mental health services, which was examined in Chapter Three. Secondly, the theme of user involvement and mental health services which was the focus of Chapter Four, will be examined. A third theme which was discussed extensively in Chapters Six and Seven was that of the closure of Foxton hospital. This can be characterised as an underlying issue within the county and an underlying theme within the study. The closure of large psychiatric hospitals in general and the shift from institutional to community care was the subject of Chapter Two. It was argued that this was an essential part of the background context to a study of mental health services. As an underlying issue, however, it is discussed in this chapter in relation to the findings on the two main themes outlined above rather than in a separate section.

Mental health and the market

This first section, therefore, seeks to examine what this study contributes to our knowledge of the impact of the changes introduced by the 1990 Act. In reviewing

the existing knowledge and literature, Chapter Three took the approach adopted by Robinson (1996) of reviewing the evidence on the impact of the changes on the principal agents involved - the purchasers (both health authorities and GP fundholders) and providers - and the interaction between them, in other words the nature of the quasi-markets in the NHS. This chapter will again adopt this approach and seek to describe what the findings from the examination of the particular context of mental health services add to the evidence in each of these areas.

Purchasers - Health Authorities (HAs)

The accounts given by interviewees who were responsible for purchasing mental health services in the case study county suggested that there had been both a gradual adaptation to and development of their new role as purchasers. This was also the picture portrayed by the existing research reviewed in Chapter Three. Change was deemed to be evolutionary rather than revolutionary and where there were developments these were at the edges of existing commitments rather than fundamental shifts in existing patterns of provision (Redmayne, 1996).

Early implementation of the 1990 changes was characterised by one respondent as a period of 'jockeying for position'. Purchasers explained that this initial uncertainty and gradual development was the result of feeling ill equipped to deal with their new role because of a lack of information and appropriate expertise. A degree of faith was put in the fact that the Care Programme Approach (CPA) would eventually provide purchasers with more detailed information about both the use of psychiatric services and the unmet mental health needs in the county. It was felt that the CPA forms, which would record professionals' and users' assessments of individual need and the care plan devised to meet that need, would give the HA better information on which to base the future purchasing of mental health services. Evidence from the interviews carried out in this study with

professionals and users suggests, however, that purchasers' optimism about the CPA may be misplaced. Both professionals and users gave the impression that user involvement in the CPA process was often minimal. The participation of users was often restricted to merely agreeing to their care plan. In such cases the CPA process would not constitute an articulation and recording of the individual needs of each user. Such perceptions and experiences suggest that the CPA may not automatically provide the HA with the kind of information that it anticipated it would in order to improve its understanding of the mental health needs in the county.

Although the focus of this research was the health service, both managers and professionals from social services were interviewed as part of the study. Their experience of purchasing mental health services in the social care sector seems to have been more positive than that of the those in the health sector. The model of purchasing introduced into social services was different from that in the health sector as it was focused more on the purchase of individual packages of care for users through the care management process. Both social service managers and social workers in the study spoke of this process giving them the ability to make changes in service provision which were of direct benefit to mental health service users. The most frequent examples given were those of residential services. Having control over elements of the mental health social care budget and therefore being able to influence where resources went had also given them the ability to put people in residential placements which were much more appropriate to their needs. The greater freedom to go outside of the statutory services provided by local authority providers had allowed them to put users, and therefore funds, into voluntary sector provided services. It was felt that voluntary sector providers were delivering services that were more flexible and responsive to the needs of a range of mental health service users.

When the health service purchasing managers interviewed were asked for examples of where the 1990 changes may have brought direct benefits to actual mental health service users, most were doubtful that there were any clear benefits that would have yet filtered down to service recipients. This would seem to suggest that the more individualised model of purchasing introduced into the social service sector may have been able to affect more immediate and direct change in the actual services that people used or received. Within the health service, purchasing was on a broader basis, for the population of the county as a whole. The contracts between purchasers and providers were also largely 'block contracts' where providers are given a fixed sum for a defined range of services. Individual services and treatment which would meet the needs of specific users are, therefore, not specified in the way that the more individualised model of purchasing within social services appeared to allow.

Purchasers - General Practice Fundholders (GPFHs)

As mentioned previously, no GP fundholders were interviewed as this was beyond the scope of the study. GP fundholding was, however, an issue that was both discussed with and raised by those that were actually interviewed for the research. GP fundholding had not made a significant impact in the area because of the low numbers of practices in the county which had chosen to join the scheme. Both managers and professionals did, though, identify tension between the GPFHs in the county and the trusts, specifically around mental health services. In the wake of several highly publicised, violent incidents involving users of psychiatric services, central government policy had urged NHS Trusts to target their work and resources towards people with severe and enduring mental health problems. GPFHs in the county under study, however, were reported to be more concerned with the majority of people with more moderate mental health problems who constitute a significant proportion of their workload. With their control over some of the budget for community mental health services they had been trying to

contract with the Trusts for more psychology and community psychiatric nurse sessions in their practices to help them address the mental health needs of their patients. The Trusts' managers resisted this on the grounds that it would divert resources away from what they saw as their priority - those with severe mental health problems.

The conflict, however, remained unresolved. Professionals 'at the coal face' who were interviewed for this study, such as CPNs, reported conflicting demands on their time and feeling that they were being 'pulled in different directions'. Both non-GPFHs and GPFHs alike were seeking help with coping with people with less severe mental health problems but GPFHs control over budgets meant that they could cause more problems for the Trusts by threatening to contract with other providers outside of the county. The role of the Health Authority in all of this seemed ambiguous. Managers in the HA admitted having sympathy with both points of view and in specific instances they seemed to have tried to placate both sides but without having established a permanent solution to the problem.

This tension between GPFHs and mental health providers has also been noted in other areas of the country (Hadley and Goldman, 1995), and in subsequent extensions to the fundholding scheme such as total purchasing and extended fundholding[1] (Lee and Gask, 1998). It could also be a tension that is set to continue. The Labour government elected in May 1997 has pledged to abolish the GP fundholding scheme and therefore individual GP practices holding their own budgets. The proposals to replace the fundholding scheme with 'Primary Care Groups' (Department of Health, 1997), however, mean that groups of GP

[1] Total purchasing is where a GPFH or group of GPFHs are delegated a budget by their health authority to pilot the purchasing of potentially all of the services not previously covered by the fundholding scheme. In practice, total purchasers have chosen to focus on a few specific areas and mental health has been a popular choice. Fifty such schemes around the country ran on a pilot basis between 1995 and 1998 with a further thirty having operated between 1996 and 1998. Extended fundholders are GP practices who are piloting the purchasing of particular areas of service provision. Nationally thirteen extended fundholding schemes ran between 1996 and 1998 experimenting with purchasing in-patient mental health services.

practices will jointly hold budgets for most of the services used by their patients. There could again be the potential for conflict, between the primary and secondary care sectors, over the appropriate use and targeting of resources for people with mental health problems.

The broader focus of the health service, reflected in the type of mental health problems it deals with, can also be related to the relative merits of the models of purchasing within health and social services identified earlier in this chapter. Social services clients are those who have been assessed as in need of social and residential care. This will tend to be those with more severe mental health problems. A broader range of people with mental health problems are seen within the health service. In common with social services, the health service will see those with severe and enduring mental health problems who are deemed as having a variety of psychiatric, social and housing needs. As highlighted above, the health service, though, also deals with those with 'less severe' mental health problems. The latter may live in relatively stable social and housing conditions but have a range of emotional and behavioural problems for which help is sought. Social services may benefit, therefore, from a more specific client group where users' needs have a more central focus within a more individualised model of purchasing.

Providers

In the review of literature in Chapter Three on the impact of the 1990 changes, it was noted that there was very little existing research specifically focused on providers. The studies which had been carried out had focused on assessing the performance of providers in terms of financial management, patient activity and operating costs. Although NHS trusts had outperformed directly managed units in all of these respects, it has been noted that without adequate comparative data, it is difficult to ascribe such success specifically to trust status rather than hospitals

pre-existing higher levels of performance dating back to before the 1990 changes (Bartlett and Le Grand, 1994). There is little existing research on the perceptions of those working within provider organisations about how trust status may have affected services.

Participants in this study from the mental health provider trusts were asked about what they thought may have been the affects of their organisation becoming a trust. There were no noticeable differences in the responses between those working in the east and those working in the west trusts in the county. In terms of the way managers and professionals felt about the impact of their organisation gaining trust status, however, there were both consistencies and differences. Both managers and professionals identified that money and financial concerns had become more important since the introduction of the purchaser/provider split. The provider managers felt that they were now much more aware of spending and costs as they had been forced to develop more sophisticated financial systems in response to the demands of purchasers, both health authority and GP fundholders, who were keen to know what money was going where. This greater concern with financial issues within the trust had become apparent to the CPNs 'at the coal face'. As discussed in Chapter Seven, they also spoke about greater financial accountability at their level by having to, as one CPN put it, 'justify whatever we want'. The CPNs also felt that the need to contain costs meant that more demands were being placed on their time without necessarily being given increased financial resources.

Beyond the greater concern with financial issues. the professionals did not seem to feel that the essential nature of the work they were doing had been profoundly affected by the changed status of their organisation. By contrast, though, for some of the managers becoming a trust had changed their role. This was primarily in terms of having greater autonomy over their organisation and the operation of mental health services. This was a feeling, however, that was not shared

universally by the managers interviewed. One manager said that he sometimes felt there had been little change with the introduction of the purchaser/provider split and that the purchasers in the Health Authority often retained 'the old District Health Authority type of mentality' and thought they were still managing the trust and its services.

The quasi-market

In terms of the relationships between the different players or the nature of the quasi-market in mental health, it has already been highlighted above that there was tension between at least one group of purchasers - GPFHs - and the mental health service providers in the county. The limited numbers of GPFHs in the area, however, meant that the relationship of primary importance in determining the nature of the market in mental health was that between the HA purchasers and the provider trusts. As Chapter Six highlighted, there had also been some tension in this relationship during the initial stages of the implementation of the 1990 changes. In the early stages of the operation of the 'market' in mental health, the relationships between purchasers and providers appeared to be quite confrontational. This was more apparent in the relationships between the HA and the East Trust with the added dimension of the closure of Foxton hospital. As the East Trust ran the services at Foxton, it would be most affected by the reconfiguration of services brought about by its closure. The East Trust was frustrated with the HA because it felt that it was not being sufficiently clear about what services it planned to purchase in the future, after the closure of Foxton. So, in this instance, the background of the hospital closure was an important factor within the relationships between local mental health purchasers and providers. This would seem to support the suggestion in earlier chapters that research into the implementation of central policies needs to pay particular attention to local circumstances. The introduction of the purchaser/provider split and the subsequent nature of the relationship between organisations was influenced by the

existing context of the impending closure of the large psychiatric hospital in the county.

By the time the actual interviews with purchasing and providing managers were being carried around 1994/5, however, the respondents had identified a shift from the initial tensions towards a more collaborative approach. The development of this more collaborative approach between purchasers and providers was seen as particularly important for an area like mental health. There are a variety of different health, social service and voluntary agencies responsible for different areas of mental health service provision. With this in mind the provider managers in the study, in particular, felt that encouraging agencies to see each other as competitors would work against the need for joint working in order to provide a network of services for people with mental health problems. Purchasers also seemed to acknowledge this and were keen to move away from an aggressive 'market' approach which emphasised competition between providers. That is not to say that competition had been abandoned altogether. Purchasers were still using competitive tendering for some aspects of mental health services such as the reprovision of long term residential care previously provided at Foxton Hospital. Overall, though, the emphasis within mental health in the county appeared to be moving towards a more collaborative approach.

Whilst the shift from a competitive to a more collaborative approach may have reflected a process of local change it is also true to say that it was part of an overall shift in the NHS policy context. It could be argued that there was an almost instant softening of the 'market' in the NHS even before its initial implementation. In the first contracting round between purchasers and providers in 1991-2, the NHS Management Executive at the centre urged caution and emphasised the need a 'steady state' where existing levels and patterns of service provision were maintained (Exworthy, 1993; Hughes, 1993; Salter, 1993). Beyond this initial caution about the rapid adoption of a 'market' approach at a

local level, the tone and language of central government in relation to the 1990 changes also began to shift over time. Terms like 'commissioning' and 'contestability' gradually began to replace those of 'purchasing' and 'competition'. Both implied a less overtly 'market' orientated approach was being encouraged. 'Commissioning' suggested a less confrontational approach between HAs and Trusts. 'Contestability' meant the ability to shift contracts between providers but providers were not expected to be constantly competing for business. Within the NHS it is probably true to say that there was always going to be a system of 'quasi-markets', operating very differently from any other 'market', because they had been set up and were being heavily controlled and regulated by central government (Pollitt, 1993).

In seeking to explain the shift in the 1990 changes and the nature of 'markets' in the NHS, changes at both a local and national level must be considered. The interplay between developments at a local and central level was emphasised by Ferlie (1994) whose work was discussed in Chapter Three. He argued that markets in health care are 'relational', 'institutionally embedded' and 'socially embedded'.

'Markets' are 'relational', in that interaction between purchasers and providers involved a process of continuing negotiation and displayed a complex history of adaptation, commitment, trust and conflict. Relationships between the mental health purchasers and providers in the case study county had gone through a process of adaptation, shifting from conflict towards co-operation.

'Markets' can be seen as 'institutionally embedded' in that relations between the purchaser and provider were regulated by higher tiers of the NHS such as the regional outposts and central parts of the NHS Management Executive, as well as the elected Ministers. Examples of this are, as noted earlier, the central

encouragement of a 'steady state' and a later emphasis on 'commissioning' and 'contestability'.

There was also evidence from the interviews with managers discussed in Chapter Six that relationships between purchasers and providers were also 'socially embedded'. Ferlie (1994) defined 'social embeddedness as meaning that there was a small elite of individuals that was maintained at the top of the purchaser and provider organisations and despite reorganisation long term careers emerged and continued. Respondents from this study talked about the social links between those in the county and the fact that many were friends. Before the introduction of the purchaser/provider split they had been part of the same organisation, developing friendships that were important for the way people interacted and worked together. Such relationships also often made the new organisational divides seem artificial. Individuals who had previously worked together may now be in conflict. A social services respondent gave the example of the difficulty of relationship with former colleagues who were now part of the independent provider organisations. After the split social services purchasers may have decided not to buy from such organisations because they may not be providing services which were seen as meeting the needs of individual users.

The findings from this study suggest that the concepts proposed by Ferlie (1994) of 'relational', 'institutional' and 'social embeddedness' may be useful for future studies in exploring the relationships between national policy, local organisations and the individuals within those organisations . This study has also suggested, through the in-depth focus on the mental health services in one county, that there are particular local circumstances and factors within specific areas of provision that affect the nature of health care 'markets'.

User involvement and participation

As well as an attempt to increase the efficiency of health and social services through competition, the changes introduced by the 1990 NHS and Community Care Act were also presented as a means of increasing and promoting consumer choice (Department of Health, 1989a; Department of Health, 1989b). Chapter Four identified the concepts of consumer choice and user participation as being very different both in origin and intent. Consumer choice is rooted in the notion of markets and individuals freely choosing between a range of products or services. User participation, on the other hand, is more concerned with the involvement and empowerment of previously marginalised groups of people such as those with disabilities or mental health problems.

As Chapter Three also noted, however, within the health and social service sectors there has been a conflation of these concepts. This conflation has had the potential to serve the interests of both the government and users. In the case of the government, measures seeking to introduce 'market' structures into the health and social service sectors could and have been promoted as offering the opportunity to increase user participation and involvement. There is some debate as to whether ultimately this is merely a 'user-friendly' packaging of changes ultimately designed to disempower professionals and professional interests rather than actually empower service users (North, 1993). Despite this, however, user organisations argued that, rhetorical or not, the emphasis on user involvement in the changes could be exploited to further their own interests and create opportunities for greater user participation in service planning and provision (Read and Wallcraft, 1992).

Through a case study of the psychiatric services of one county, a chief aim of this study was to explore the extent to which the 1990 changes *had* offered opportunities for enhanced user involvement in mental health services. Even

within one county, however, there are different levels and degrees of user involvement. Drawing together the findings from Chapters Six and Seven, there are three main levels at which user involvement was examined in this research. These were: the 'strategic'; the 'facility'; and 'individual' levels. This goes beyond the typology put forward by Glennister (1994), who made a distinction between 'immediate' and 'distant' participation. 'Immediate' participation is where users are involved in decisions concerning treatment, and 'distant' participation is involvement in the planning of mental health services. The 'strategic' level, which was highlighted in Chapter Six, concerns decisions about the purchasing or provision of services. This generally relates to mental health services overall as opposed to the second level - the 'facility' level, also discussed in Chapter Six - which concerns the planning and operation of specific mental health units in the county such as a community mental health centre or a psychiatric in-patient unit. Finally, as discussed in Chapter Seven, the 'individual' level concerns decisions about users' own care or treatment.

In broad terms, at each of these three levels the degree of user involvement varies from paternalism to consultation through to participation. Paternalism is defined here as where there is no involvement by users and decisions are made by either managers or professionals on their behalf. Consultation in this context is interpreted as where reference is made to the opinions of users but ultimately decisions are still taken by managers or professionals. Participation is used here to mean that decisions are jointly agreed and taken by managers or professionals and users, in other words where users are an active participant in the process. Figure 4 below shows how the concept of levels and degrees of user involvement could be represented visually.

In seeking to map out the nature of user involvement in the county, reference to the research findings, shows, however, that the degree of user involvement at each level is multi-dimensional. It would be too simplistic, for example, to place an

'X' below 'Paternalism' at the 'Strategic level'. As will be explored in more detail below, at each of the levels in the county there are elements of paternalism, consultation and participation.

Figure 4: Visual representation of the levels and degrees of user involvement

	Paternalism	*Consultation*	*Participation*
Strategic level			
Facility level			
Individual level			

The strategic level

There seemed to be very little user involvement in the mental health joint planning mechanisms between health and social services in the county. It was recognised by the purchasers, though, that this was a problem that needed to be addressed for services in general and not just mental health. To this end, there had been attempts to set up a network of individuals from organisations representing service users who would be involved in the joint planning mechanism. Around 1994 and 1995, however, when the interviews for this study were carried out this process appeared to have stalled with the voluntary organisations involved dissatisfied with the structure proposed by the purchasers to allow them to become involved in decision making. Even if an agreement could be reached on an appropriate structure, however, as was identified in Chapter Six, at that stage it was clear that the network would still only involve organisations such as voluntary groups who would *represent* users rather than the active involvement of users themselves. The process at this level would still, then, be largely paternalistic with managers and representatives making decisions on behalf of users. The fact that a structure was being proposed which *represented* rather than *involved* users perhaps reveals

the extent of development of user involvement at the 'strategic' level within the county. None of the users interviewed for this study gave any indication that they would be interested in being involved at a 'strategic' level. The managerial respondents had highlighted the problems of engaging users who would represent the views of mental health service users as a whole. They gave no indication, though, that they were actively trying to find users who would be able to become directly involved at the 'strategic' level.

In exploring the attitudes of purchasers towards user involvement, as highlighted in Chapter Six, all said that they were committed to the principle of user participation. In practice, though, purchasers did not seem to be making use of mental health service users to increase their knowledge and expertise about mental health services. Earlier in this chapter it was noted that purchasers openly acknowledged that this was an area where there was room for improvement. As others have noted the experience of mental health service users can be seen as an important source of knowledge and information for those managing services on the basis that 'it is the people eating the meal that know best what it tastes like' (Muijen, 1998).

At the strategic level the degree of user involvement in the county cannot wholly be characterised as paternalistic because there was some consultation taking place. As discussed in Chapter Six, the purchasers consulted with all those in the health, social service and voluntary sector in the county with an interest in mental health on the closure plan for Foxton hospital, the large psychiatric asylum in the county. As part of this process both the east and west community health councils (CHCs) organised events to obtain users' views on the closure plan. These were then fed back to the purchasers. The researcher was given access, by the health authority, to much of the documentation around this consultation process. It was, therefore, possible see that the health authority had written responses to the CHCs about the points raised by the users during the consultation process such as the reprovision

of services from Foxton on the site of the Radley Unit, where services were felt by some users to be poor and already overcrowded. By the end of the case study period of the research in April 1996, however, Foxton had not yet closed. So, what is less clear is the extent to which in the long term the health authority will have acted in accordance with users views. This is a key issue since, ultimately, consultation with users is a wasted opportunity if views and opinions are merely collected and they are not taken into account when decisions are made (Quality Assurance Project, 1997).

Participation by psychiatric service users was very limited at the strategic level. As has already been noted above, purchasers were struggling to involve users in their own decision making processes and planning mechanisms. Within the county, though, there was also a lack of pressure 'from below'. There were practically no user-led groups actively campaigning for a voice and influence at the strategic level. The lack of a strong, local, campaigning mental health voluntary group which has played a role in stimulating user involvement at a grassroots level in other areas was also identified by both managerial and professional interviewees as a significant gap in the county. This meant that it was often down to those in the statutory health and social services to encourage user involvement and participation. There is, however, almost an inherent contradiction in an essentially 'bottom-up' process like user participation being set up by a 'top-down' initiative from those whose job it is to plan and provide mental health services (Whiteley, 1994).

The facility level

The degree of user involvement in the in-patient units in the county seemed to be largely paternalistic. Both the Radley Unit in Trentham and the Buckler Unit in Riverbank had advocacy workers, funded by the HA and employed by a mental health voluntary group in the county, who visited and could try to address the

problems or complaints of individual users. It was not clear from the data in this study what power or influence the advocacy service was able to exert because none of the users interviewed had any experience of the advocacy service. Neither the Radley or Buckler Unit seemed to have a patient council or user group which could try to influence the running of the units on an ongoing basis. It could be that such groups may be difficult to organise with the transient nature of those using in-patient services. With people often staying in the units only for short periods of time, there may not be a consistent membership for such groups to draw on. Managerial respondents proposed another possible explanation. They argued that extensive user involvement during the acute stages of mental health problems was particularly difficult. When people are severely disturbed or distressed, they may not be particularly interested in engaging in user groups to discuss their views about services. Their priority and that of the staff would probably be getting 'better' so that they can be discharged from hospital.

A lack of consultation with users about the nature and running of psychiatric in-patients units in the county would seem to be evident from the way that in-patient services attracted a great deal of criticism from the users who were interviewed for the study. Users complained that the daily regime in them was often highly structured in terms of meal times and the administration of medication. They, therefore, seemed 'old fashioned' with one user commenting that; 'It's like "One Flew Over the Cuckoo's Nest"'. It was felt that there were few activities to do during the day and the units were also in need of re-decoration and modernisation. Similar criticisms were raised by users, specifically about the Radley Unit in Trentham, during a consumer audit of mental health services carried out independently on behalf of the health authority. The fact that these facilities attracted such criticism would seem to suggest that those running services were not consulting with and listening to users and then providing services in accordance with their preferences. It would seem that this is part of a national problem since, as noted in Chapter Four, other studies have consistently identified

significant user dissatisfaction with mental health in-patient services (McIntrye *et al.*, 1989; Barham and Hayward, 1991; Rogers *et al.*, 1993). It could be argued that dissatisfaction with in-patient mental health services is inevitable given that a significant proportion of those admitted will have detained under the Mental Health Act and will therefore be there against their will. Yet, there were respondents in this study and those in the study by Rogers *et al.* (1993) who whilst acknowledging that their state of distress was such that they did need time in hospital, were still critical of the in-patient services they received. Whilst, in the short term people recognised that they had been helped over their initial period of crisis, they did not feel that in-patient services had made a significant contribution to addressing their underlying problems. This suggests that services are offered to people based on the nature of pre-existing provision rather than being specifically designed to meet individual users' needs.

There was evidence, however, of both consultation and participation at the facility level in the county at the community mental health centres (CMHCs) in Sheerwater and Stackbridge. Both centres had user groups which met regularly and were able to influence the running of the units through user representatives on their respective management committees. Although the user group at Sheerwater CMHC was initially set up by the manager of the centre, when the researcher visited and spoke to members of the group, it seemed clear that he had now withdrawn and the group was now controlled by the users themselves. Members of the group felt that they had a strong influence in the running of the centre. Clearly, then, there were examples of active user participation in some aspects of mental health service provision in the county. Such participation had been largely dependent, however, on the willingness of professionals to initiate it and crucially a willingness to step back and allow users to take control. It was highlighted earlier that there is some scepticism about user involvement initiated by professionals or managers (Whiteley, 1994). It is felt that involvement which does not emerge from demands by users themselves (or from the 'bottom-up') will

be inherently weak. In the absence of 'grassroots' pressure for involvement, however, the examples of the CMHCs in the case study county would seem to suggest that participation initiated by professionals or managers can be successful, as long as significant enthusiasm develops amongst users so that they can eventually take control of the process themselves. This also, obviously, requires a willingness from managers or professionals to relinquish control over the process.

The greater level of involvement at the CMHCs compared with the in-patient units may have been a reflection of the more stable and consistent client group at the former. A range of social care was provided at both CMHCs in the county by a mental health voluntary organisation. Drop-in facilities for people to socialise and have meals were provided at the centres, as well as more structured facilities such as discussion or arts and craft groups. Such activities tend to involve people over a longer period than the short term stays within in-patient units. At the CMHCs there may be more opportunities to engage people in user groups on an ongoing basis than is possible with the transient populations within hospitals.

The individual level

Some professionals interviewed in the study freely admitted that there were certain mental health service users who had very little say at an individual level about the kind of care and treatment they received. They were specifically talking about those who had severe and long term mental health problems, many of whom were still institutionalised in Foxton hospital. In these cases professionals felt that there was little or no involvement on the part of the user and that decisions were basically made for them by professionals. Such paternalism may seem undesirable but in cases where people are severely disturbed it may also be unavoidable. Those admitted compulsorily to mental health services in the county were also, by definition, treated paternalistically. If they had been detained in hospital under the Mental Health Act then clearly someone else was making

decisions on their behalf. Those users interviewed in the study who had been compulsorily admitted to hospital, though, did not always resent having decisions made for them. At the time they may have objected to being forced to go into hospital and take medication. Looking back, however, they accepted they were very distressed and were grateful that when they needed help they were able to get it, even if it had meant a degree of compulsion. One user repeatedly used the phrase 'cruel to be kind' to describe his feelings towards staff who had 'sectioned' him or given him medication by force. Clearly, given the small numbers of users interviewed for this study, this does not represent any definitive statement about how users feel about being compulsorily detained but it does highlight the fact the even those on the receiving end realise that difficult but practical choices have to be made within mental health services. Such decisions may ultimately be paternalistic but in the longer term they may also be justified to prevent harm or neglect.

More generally within mental health services in the county, some of the professionals interviewed claimed that users were consulted at an individual level about the kind of treatment and care they received. In explaining in more detail, however, how users were consulted, professionals seemed to hint at a possibly limited interpretation of consultation. They related consultation to the reviews undertaken as part of the Care Programme Approach. In Chapter Six it was noted that one CPN said :

> '. . . we involve users and relatives at an early stage and get people to agree to their care plan so they know what is expected. The Care Programme Approach stipulates that people have to agree to and sign the care plan.'

These comments indicate merely a 'rubber stamping' by users of their care plan. There is no indication that a user's views, preferences and concerns would necessarily be part of the process. Other professionals felt that users were not extensively consulted or involved in decisions about their individual care. They

argued that that was reflected in the fact that much of what users received was based on what was already offered by mental health services rather what users felt they wanted or needed. This was also echoed by the comments of some users interviewed in the study. Although they seemed to have clear ideas of what kind of services they wanted to access it did not seem that they were able to do so. Examples, that were highlighted in Chapter Six, were of users who wanted access to psychotherapy, opportunities to return to employment and more flexible occupational therapy which could be undertaken at home. The larger scale study of users views of mental health services undertaken by Rogers *et al.* (1993) also identified that users wanted more access to psychotherapy or 'talking treatments' but a third of the 512 users surveyed reported that, despite wanting to access to such treatments, they were unable to.

At the individual level of mental health services in the county, then, there did not seem to be a high level of active participation by users. Those users who were dissatisfied with some aspects of the mental health services they were receiving would have liked more say and involvement in the decisions about their care. As reported in Chapter Seven, however, many of the users interviewed were satisfied overall with the care and treatment they were getting. They did not feel that they wanted to be more involved. This would seem to suggest that increased participation or involvement may not be demanded by all users. Their expectations of what mental health services could offer them or do for them seem to have been satisfied. Greater participation or involvement was only desired by those users who were critical of aspects of the mental health services offered to them.

By exploring the degrees of paternalism, consultation and participation at each of the three levels (strategic, facility and individual) of mental health services in the county, this section of the chapter has tried to illustrate the multi-dimensional nature of user involvement within a local psychiatric service.

Conclusion

This chapter has attempted to draw together the findings from this study, previously discussed separately in Chapters Six and Seven. It has also drawn on the existing literature examined in Chapters Two, Three and Four, to establish how this study contributes to the work around the two key themes of the thesis: the introduction of 'markets; and user involvement, as well as the underlying theme of the shift from institutional to community care.

There are certain key interfaces between these three issues within the case study county. The particular stage in the overall policy shift from institutional to community care in the county had an impact on the nature of the interaction between mental health purchasers and providers. Uncertainty about the closure and reprovision plans for the large asylum in the county created particular tension between the HA and the East Trust responsible for the services at Foxton. The introduction of the purchaser/provider split in the county had already caused some tension as people adapted to their new roles and the uncertainty about the closure created an added dimension.

The underdevelopment of user involvement and participation in the county may have helped to explain the continued use of facilities such as Foxton. The lack of any strong, local user led groups and organisations able to challenge those planning and providing mental health services may have ensured that the extensive in-patient facilities, which have been often the subject of criticism by users, continued to dominate the psychiatric services in the county, at the expense of the development of more community based provision, which is generally preferred by users. The closure had, however, created an opportunity for greater user consultation in the county. The HA consulted with a wide range of groups, including user groups, on its plans for the reprovision of services from Foxton.

In terms of the interplay between the introduction of the 'market' changes and user involvement, there did not seem to be much evidence from this study that the 1990 changes had yet led to greater level of user involvement in the case study. The managers within the county were certainly aware of the issue but there seemed to be a lack of specific initiatives. Again there was little pressure from the 'bottom up' for greater user involvement because of the lack of strong existing mental health voluntary and user groups in the area. Although user participation was taking place at some facilities within the county much of this had had to be stimulated by trust staff.

CHAPTER NINE: CONCLUSION

Introduction

The Labour government, elected in May 1997, set out its blueprint for the health service over the next 10 years in a White Paper entitled 'The New NHS' (Department of Health, 1997). The White Paper sets out a programme of organisational change for the NHS that will see many of the purchasing functions of health authorities being transferred to Primary Care Groups (PCGs). PCGs will consist of clusters of GP practices serving populations of about 100,000 and when they begin in April 1999 will initially be able to operate at one of four levels. At level one PCGs will advise and support health authorities in commissioning care for their populations. Level two PCGs will take devolved responsibility for managing the budget for health care in their area but will be formally part of their local health authority. At level three PCGs will become established as free-standing bodies commissioning care for their populations but remaining accountable to the health authority. And finally level four PCGs can become Primary Care Trusts which are again free-standing bodies accountable to their health authority for commissioning care but with added responsibility for the provision of primary and community health services for their populations (Department of Health, 1997). The NHS, therefore, appears to be facing another period of organisational change and restructuring.

This study has focused on the implications for mental health services of the last major health service re-organisation introduced by the 1990 NHS and Community Care Act. The conclusion to this study will focus on four main areas. Firstly, this chapter will briefly reiterate the changes that were introduced by the 1990 Act. Secondly, the conclusion restates the main findings of this thesis in terms of the three main reseach questions and the conceptualisation of social policy set out in the introductory chapter, highlighting what is new or unique in terms of the

findings and methodology of this study. Thirdly, it will examine what the findings from this study say about the next set of organisational structures and reforms proposed for the 'New NHS'. Finally, the observations that this study can offer about research into organisational changes in the health service in general will be discussed.

The 1990 NHS and Community Care Act

The 1990 Act introduced by the last Conservative government sought to introduce 'market' structures into the health service. The separation of purchasing and providing functions within both sectors was a key element of the changes. In the health service health authorities were became responsible for assessing the needs of their population and purchasing or commissioning services to met those needs. The day to day operation or provision of services in the NHS had become the responsibility of trusts.

These changes were promoted as a means of improving the efficiency of the health service. Competition between trusts in the 'market' would force them to offer the best services at the cheapest price in order to win or keep contracts with health authorities. Effectiveness would also be increased within the health service by allowing organisations and individuals to have control and take decisions at the appropriate levels. Health authorities would be able to concentrate on meeting the health needs of their populations and trusts would have the power to manage the direct provision of services without unnecessary interference from bureaucracy within health authorities.

It was also argued by the government that these changes would improve the services offered to patients because competition would increase the quality of services. The Act also stressed that patients or users would be given more say as

health authorities and trusts were encouraged to consult and involve them in decision making within the health service.

Purchasing, providing and participating in mental health services

As identified in the introductory chapter, this study had three main research questions which it sought to address. These were:

- What has been the impact on local level mental health actors of the 'market' orientated approach of purchasers and providers introduced by the 1990 Act?

- In the light of the 1990 Act, to what extent has there been an increase in user involvement within mental health services?

- What impact are changes in the organisation of services perceived to be having on the care and treatment that people experiencing mental health problems actually received?

In terms of the first question, this study has been able to identify the particular problems that the 1990 changes have presented for psychiatric services at a local managerial level. One of the main effects on local mental health actors in the case study county during the initial introduction of the changes was that it created some instability between the various local agencies involved in mental health services as they adapted to their new roles and responsibilities. The introduction of the 1990 Act also created a tension for mental health services in the county between competition and collaboration. Joint working between a variety of mental health agencies was being emphasised by central government and various inquires into failures and tragedies within psychiatric services. Collaboration, however, was being threatened by a more fragmented and competitive environment created by the 1990 Act. The uncertainty surrounding the closure of a large mental hospital

in the county created an added tension between purchasers and providers. The trust that operated the hospital was unsure what services the health authority would purchase from them once the hospital had closed and the negotiations on this issue had strained the relationship between the trust and the health authority. The study also found an underdevelopment of the purchaser function in mental health with most personnel and information being on the provider side of the purchaser/provider split. This meant that the managers within health authority often felt they lacked the knowledge about the mental health needs of the local population which they needed to effectively carry out their purchaser role. Previous research has not highlighted these particular findings because most research on the impact of the 1990 Act has tended to examine health services in general. The specific focus on mental health services in this study, however, has been able to highlight the particular problems and issues the 1990 changes posed for a local psychiatric service. The study also suggests that the local context has a bearing on organisational changes introduced from the centre, the closure of the large mental hospital being the prime example of this.

In relation to the second research question, within the county studied for this thesis, the level of user involvement does not seem to have been significantly altered by the introduction of the 1990 Act. As highlighted in Chapter Four user involvement has become a significant issue with health and social services in general. Although all managers and professionals interviewed for the study recognised the importance of user involvement, there was a lack of specific initiatives to stimulate greater user participation. Although part of the remit of health authorities had been to consult with user groups about the planning and provision of services, in this county it did not appear that the purchasers had yet fully got to grips with this aspect of their role. The local context again, however, had a part to play here. The lack of existing strong voluntary or user groups meant that there was little pressure from the 'bottom-up' for greater user involvement in decision making. Stimulation of greater user participation was,

therefore, the responsibility of managers and professionals. Although there were examples of those within the county who were keen to take on this role, it could be argued that it may not always have been seen as in the interests of staff to encourage greater participation which could lead to criticism of their work and existing services.

In examining user involvement this study took the distinctive approach of analysing three levels within mental health services. These were: the 'strategic' level; the 'facility' level; and the 'individual' level. Previous studies have tended to examine user involvement at the 'strategic' and/or the 'individual' level. Neglect of this 'facility' level in this particular study could have led to the unwarranted conclusion that there was no user involvement within mental health services in the county. By examining all of these three levels the study was able to offer a broader and more in-depth analysis of user involvement and participation within a local mental health service. The study also highlighted that within these three levels there were elements of consultation, participation and involvement. Rather than offering a simplistic interpretation of user involvement at each level, the thesis presented a more multi-dimensional approach. In summary then the distinctive theoretical proposition suggested by the findings from this study is that in order to analyse mental health service user involvement at a local level consideration must be given to participation at three main levels: the 'strategic' level; the 'facility' level; and the 'individual' level.

In relation to the third research question outlined above, this research confirmed the findings of previous studies that the 1990 Act has had little impact on the actual treatment and services that users received at 'the coal face'. This was established through interviews with managers, professionals and mental health service users themselves. The wide range of groups and people interviewed for the research constitutes another distinctive characteristic of this study. By interviewing a variety of individuals within the mental health services of the case

study county the study was able to examine the effects of the 1990 Act at both a managerial and an operational level.

Very few studies of the impact of the 1990 Act have sought to consult directly with users about the effects of the changes. Studies involving mental health service users are rarer still. The study, however, has demonstrated that it is possible to access and gain good information from users of psychiatric services, who are often characterised as being unable to express a view. This study also interviewed a broader range of mental health service users than many previous pieces of research. Existing research has often focused on long term users of mental health services and in particular those who are, or have been, in-patients. The research for this thesis also included users who had not been in-patients and whose contact with psychiatric services was solely with staff based and working within the community. This is a group who have become increasingly important as mental health services shift from an institutional to community care model and less emphasis is placed on hospital and in-patient services.

In the discussion of conceptualisations of social policy in Chapter One, it was noted that the nature of the 1990 Act suggested the need for an analysis which took elements from both top-down and bottom up approaches, as described by Sabatier (1993). It was suggested that as a 'meta-policy' adjustment to the 'programme shell' (Ham and Hill, 1993), the 1990 Act may have had the potential to effect service outcomes but its primary impact was likely to be the 'implementation structure' or the relationships between actors within the local level policy network. The findings outlined above suggest that the primary impact of the 1990 Act has been on the relationships between the main mental health actors in the county or, in other words, the local level mental health policy network. It was the perception of both managers and professionals that there had been little impact on the actual services provided to users or, in other words, there had been few service level outcomes. The user interviews also provided little

evidence to support the notion that the organisational changes had had any implications for the mental health services that users received, particularly in terms of increased user choice which, at the outset of the 1990 Act, was emphasised by central government as an intended outcome of the changes. An important caveat here, though, is that the interviews were carried out with a limited number of users. The findings from the user interviews, therefore, can not be assessed as representing definitive evidence. Other users may have been more positively affected by the changes introduced by the 1990 Act. Based on its findings, this study, again, suggests the theoretical proposition that the changes introduced by the 1990 have had little or no direct effect on the services mental health service users receive.

The research also suggests that the bottom-up approach of 'backward mapping' (Barrett and Fudge, 1981) is useful in assessing the effects of a top-down intervention. The focus of the study has largely been the bottom-up unit of analysis of the relationships and interactions within the 'implementation structure', in this case local mental health actors and organisations. By examining this 'implementation structure' as a single in-depth case study, this research has been able to discern the issues of primary importance to local level actors within the periphery and explore the interaction between these and a top-down intervention from the centre, in this case the changes introduced by the 1990 Act. A specific example of this is that the separation of local managers into distinct purchaser and provider organisations was seen as having a role in the local issue of closing the large asylum in the county. The purchaser/provider split was seen by some respondents has having encouraged the closure process and by others as having impeded it.

This study has not simply viewed local level actors as enablers or inhibitors of top-down interventions but, as suggested by bottom-up approaches to policy analysis, actors in their own right with their own set of concerns and priorities.

The implementation of the 1990 changes has not been viewed as a simple top-down process. Rather, the interplay between the top-down and bottom-up policy agendas has been explored by focusing both on the 1990 changes and its effect on and interaction with the concerns of actors within the local mental health policy network.

Overall, then, the study can be seen as adding support to the assertion made by Sabatier (1993) of the utility and validity of attempting to synthesise top-down and bottom up approaches to policy analysis.

Mental health services in the 'New NHS'

Within the White Paper 'The New NHS' the Labour government has pledged to keep the purchaser/provider split within the health service. It is argued, however, that competition will no longer be a feature of the health service. The approach advocated by the White Paper is a 'third way' for the NHS. This means a rejection of the 'top-down' planning model of the 1970s but it also moves beyond the competitive approach of the early 1990s. Instead, a collaborative approach will be encouraged but with the retention of the purchaser/provider split. Decentralised responsibility for operational management will be retained by NHS trusts. In many respects participants within this study were advocating just such an approach within local mental health services. Both purchasers and providers were emphasising the need for greater collaboration between all local mental health agencies in order to prevent the fragmentation of services and ensure that co-ordinated services are provided to people with mental health problems. In the 'New NHS', 'contracts' between purchasers and providers are to be replaced by 'service agreements'. The only difference identified so far between 'contracts' and 'service agreements' is that the latter are expected to be renewed at intervals of between three and five years as opposed to the current annual renewal of 'contracts'. It is contended that this will create greater stability in the

relationships between purchasers and providers. Trusts, it is also argued, will be able to plan on a longer term basis than is currently possible.

At one level these arrangements would seem to recognise the reality of the organisation of health services at a local level. This study identified that within the mental health services of the case study county there was not a 'market' of alternative providers willing or able to compete for services. The reality was there were two NHS trusts in the East and West of the county, respectively, providing the majority of mental health services. Given users' criticisms of existing services in the study, however, will there be even less potential in future for provision to be changed by purchasers if they are locked into three or five year agreements with providers? It seemed that purchasers had taken little opportunity to try, through contracts, to encourage providers to offer services which were preferred by mental health service users or met their needs. This must be set against the slow development of the purchaser role, identified by respondents. In the future, with improved information, purchasers may increasingly be in a position to challenge providers yet with the proposed changes it is not clear whether long term 'service agreements' will allow them to do this.

A major element of the 1997 White Paper, highlighted in the opening section of this chapter, was the creation of Primary Care Groups (PCGs). PCGs are intended to replace the fundholding scheme. Rather than the individual practice budgets of GPFHs, PCGs will consist of all the GPs in an area having the ability jointly to control the budgets for populations of 100,000. Within this study tensions were identified between GPFHs and trusts around mental health services. GPFHs were seen by trusts as attempting to divert resources and staff away from the specific government identified priority of people with severe and enduring mental health problems towards those with less severe mental health problems who represent a greater proportion of GPs' workload. Given the small numbers of GPFHs and their control over limited funds, trusts in the county were able to ignore GPFHs'

attempts to attach or base specialist mental health staff to GP practices. The trusts felt that this would result in those with severe mental health problems becoming a lower priority for mental health professionals such as CPNs as they became swamped by those in primary care with 'mild' and 'moderate' mental health problems. With PCGs, however, representing greater numbers of GPs and, therefore, having control over greater levels of resources, trusts and the mental health staff working for them may find themselves increasingly 'pulled in different directions' between the competing priorities of people with severe and less severe mental health problems.

Researching organisational changes in the NHS

This thesis ends by discussing the process of attempting to assess the impact of policy interventions like the NHS and Community Care Act 1990. This study may provide some insights for future research into the effects of re-organisations within the health service.

This study has shown little evidence that the organisational change initiated by the 1990 NHS and Community Care Act has a significant impact on the care, services and treatment that people with mental health problems receive. This conclusion is based not only on interviews with users themselves but also with mental health service managers and professionals who perceived that the changes had had little direct impact on users and services. Such a conclusion gives rise to a number of questions and interpretations.

Firstly, it could be argued that the changes did have an impact but the research was not using the right methods to detect it. The study used a qualitative approach and focused on perceptions of change by key managers, professionals and users. It could be argued that a more quantitative approach which sought to measure shifts in patterns of service use, such as number of in-patient admissions, would

have allowed the study to detect changes which were not necessarily apparent to interviewees. The precise effects and outcomes of the organisational changes, however, would have to be known at the outset of the research in order to establish which indicators should be measured. The potential effects of the 1990 changes, though, were not known at the outset so a more flexible and qualitative approach was needed.

A second issue, could be that there is a relationship between organisational change and the services users receive but their impact is longer term. Even research carried out three to five years after the introduction of structural reform, as this study was, may have difficulties in detecting the effects of change which may take many years to filter down to 'the coal face' and the service that users receive. If this is the case, this represents a problem not only for researchers but also policy makers. If they are unable to demonstrate a positive outcome for organisational changes it may be difficult for them to gauge the impact of their reforms. It will be problematic for them to establish which policies are successful and which are not. The element of the 1990 NHS changes that was the subject of most research was fundholding. Yet as identified in Chapter Four the evidence about the efficacy of the scheme in range of areas remains ambiguous and inconclusive.

A final issue is that perhaps a greater degree of cynicism is required in the assessment of policy initiatives. It could be argued that centrally formulated policies are not necessarily designed to achieve improvements in the services provided to users. They should perhaps be viewed within the political context in which they were formulated. The changes within the 1990 Act could be represented as part of a wider ideological agenda on the part of the then Conservative government to introduce 'market' forces into the public sector. The reforms may not necessarily have been rationalised directly to improve patient care but part of a more dogmatic assertion that the principles of the 'market' and the private sector would improve efficiency within the NHS. The 1990 Act could

also be viewed as an attempt to stave off the NHS crisis in the winter of 1987-8, with the government giving the impression that it was taking concerted action. If one were to adopt these more cynical interpretations, however, the fact would still remain that there are managers and professionals at a local level who are charged with implementing these changes. The reforms would still have a human and financial cost that should be assessed. The 1990 changes did affect peoples jobs and roles. If this disruption cannot be shown to bring improvements to services and users, then it raises fundamental questions of how justifiable such changes are. Without clear indications of the impact of changes, it may become harder to justify widespread organisational change within the health service to those who use it and those who work within it. Research, therefore, should continue to have a key role in discerning the impact of policy changes.

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APPENDIX A: MANAGERIAL INTERVIEW GUIDE

1. Purpose of the research study and this interview is to discover how the some of the changes introduced by the 1990 NHS and Community Care Act haved affected the planning, management and provision of mental health services.

2. Series of questions to explore this.

3. Check OK to tape the interview.

4. Reassure about confidentiality, anonimity and access to tapes.

THE IMPACT OF THE PURCHASER/PROVIDER SPLIT IN MENTAL HEALTH

1. What do you think have been the advantages of the introduction of the purchaser/provider split in mental health?

2. What do you think have been problems associated with the introduction of the purchaser/provider split in mental health?

3. Are there any aspects of the providing mental health services which distinguish it from the provision of other health and social services?

- Is there anything about 'mental illness' or mental health services which requires a different approach?

4. How, as providers, do you establish what kind of mental health services you offer in the county?

5. What impact do you think the introduction of GP Fundholding has had on mental health services in the county?

- Do you think that there will be an increase in GP Fundholders?

- What do you think will be the consequences of this for mental health services?

6. Would you say that certain groups of 'mentally ill' people have benefited or been disadvantaged, more than others by the introduction of the changes?

- Are there any particular issues surrounding people from minority ethnic groups and mental health services?

7. How important are national policies and priorities compared with locally determined aims and objectives in shaping mental health services in the county?

8. Do you think that certain models of provision are favoured more than others in this county?

- How is 'mental illness' itself viewed? Is there a dominant approach?

RELATIONSHIPS BETWEEN THE VARIOUS LOCAL GROUPS AND AGENCIES INVOLVED IN MENTAL HEALTH

9. How are mental health services affected by the number of different agencies and stakeholders involved?

10. How well do you think that health and social services liase/collaborate locally with regard to mental health services?

Purchasers and providers

11. What is the nature of the relationship between the purchasers and providers of mental health services in the County?

- How frequent is the contact between them?

- Who sets the agenda and what do they discuss?

Voluntary groups

12. How do you think that voluntary groups are reacting to the new environment of purchasers and providers within mental health?

FOXTON HOSPITAL CLOSURE

13. How will the closure of Foxton affect mental health services locally?

14. What do you think were the main issues which arose out of the consultation process over the Foxton Closure Plan and the Strategic Direction Statement for Mental Health Services?

USER INVOLVEMENT AND PARTICIPATION

15. Do you think that the nature of 'mental illness' itself has any bearing on the effectiveness of user involvement and participation in mental health services?

- Traditionally mental health users' views have been ignored. Do you think this attitude still exists?

- Are people with mental health problems seen as unable to articulate their views?

16. Have there been any structures put in place locally to involve users?

17. Do you think that user groups and advocacy services are able to inform the planning process and service provision in the County?

- If so, how?

18. Do voluntary agencies have a role in representing the views of users?

THE DIRECT IMPACT OF THE CHANGES ON PEOPLE WITH MENTAL HEALTH PROBLEMS

19. What impact has the purchaser/provider split had, locally, on users' choice and access to a range of services?

20. How do you think that the introduction of the Care Programme Approach in health and Care Management in social services has affected the services and care that people with mental health problems receive?

AND FINALLY

21. Is there anything else that you think it is important for me to know?

- Or anything else you would like to say?

APPENDIX B: PROFESSIONAL INTERVIEW GUIDE

1. Summarise the nature and purpose of the research and reassure about confidentiality.

2. Any questions you want to ask?

3. Is it okay to tape the interview?

4. Make sure consent forms have been signed.

Introduction

Perhaps we could begin by you telling me a few things about your background. For example, when and how you first became a social worker/CPN? If you've always been within the mental health field? How long you've been in the county?

What would you say, working as a professional in the mental health field, were the main issues or your chief concerns at the moment?

Checklist

Impact of the NHS and Community Care Act and business or private sector values

Effects of management and staff reorganisation

Users first contact with and access to services

Choice

Information

Involvement and participation

Foxton closure

Care programme approach and care management

Relationships with other professionals

Relationships between different agencies

'Worried well' vs. severly mentally ill

Improvements

Anything else you want to say

Impact of the NHS and Community Care Act 1990?

What impact, if any, have the changes had on your work as a professional?

Has the purchaser/provider split made any difference?

a. Has the fact that you are now working for a Trust had any affect?

b. What kind of effect the reorganisation of Social Services in to purchasers and providers have on you?

To what extent do you think 'business' or private sector values have made an impact on mental health services? Is this a good or bad thing?

Users' first contact with services

Where do most of the referrals come from? - GP? Is self referral available?

How is it determined who is seen by the service?

How is it determined who sees a particular person?

Do you as a professional have any types of people you prefer to see?

Do people specialise within the team?

Do people ever specialise in terms of race or gender?

Choice of and access to different types of services

Do you think that users have a choice of services?

How easy is it for people to access the services that are on offer?

Participation and involvement with care and treatment

How important do you think user involvement and participation is?

Do you think users now have a greater say in

a) how services are organised and run?

b) the kind of direct care and treatment they receive?

What kind of information is provided to users about the services that they receive or are on offer?

Do you think the information should or could be improved?

If so how?

Do you think more information should be provided?

If so what?

Care manangement and the care programme approach

What has been the impact of the Care Programme Approach?

How useful do you think it is?

How well do health and social services collaborate locally?

How well do you work with voluntary groups?

Overall views and opinions on the care and services provided

What do you think overall about the mental health services provided?

Is there anything that could be improved?

Is there anything you think should be available but isn't?

Are there any particular problems in this county?

Anything else

Is there anything else that you feel it may be important for me to know?

Is there anything else you would like to say?

Are there any other ways that you think things could be improved?

APPENDIX C: USER INTERVIEW GUIDE

1. Introduce myself and give some of my background, who I am.

2. Summarise the nature and purpose of the research and reassure about confidentiality.

3. Any questions you want to ask?

4. Are you happy to do the interview? If yes, get consent form signed.

5. Is it okay to tape the interview?

6. You can stop the interview at any time and if there are any questions you do not want to answer, just tell me and we will move on.

Introduction

Perhaps we could begin by you telling me a bit about what sort of contact you've had with the services? How and when you first came into contact with them?

Checklist

Access to services

First impressions

Help that you felt you needed

How this compared with help recieved

Choice

Information

Involvement

Helpfulness of care and treatment

Improvements

Anything else you want to say

First contact with services

When did you first come into contact with the services?

How did you first come into contact with the services?

What were your first impressions?

What kind of help and services did you get?

What kind of help did you feel you needed?

How did the kind of help you actually received compare with what you felt you needed?

Did you find it easy to get help?

Choice of and access to different types of services

Did you feel that you were offered any choice of support or services?

What kind of information have you been given about what is available?

Participation and involvement with care and treatment

In what ways have you been consulted about what kind of help has been given?

Do people listen to your views?

Do you think this is important?

How much information have you been given?

What sorts of information have you been given?

Do you feel you would like more?

About what, in particular?

Overall views and opinions on the care and services provided

What do you think overall about the services that you have received?

How helpful have you found the things that have been provided?

What was most helpful?

What was least helpful?

Do you think there are any ways in which they can be improved?

Is there anything that you think should be available but isn't?

Anything else

Is there anything else that you want to say about the service?

Is there anything else that you feel it may be important for me to know?

Are there any other ways that you think things could be improved?